EVALUATION REPORT

ASSIST Trauma Care: Guiding Young Minds

Feasibility and pilot study report

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University of Hertfordshire UH

YOUTH ENDOWMENT FUND

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About the evaluator

This independent report, funded by YEF, has been produced by a multi-disciplinary team based at the University of Hertfordshire (UH). The evaluation team has proven knowledge and competence in the field of youth violence and crime and considerable experience conducting research involving vulnerable and at-risk children and families and evaluating the feasibility of different projects.

As members of YEF's Evaluation Panel with responsibility for evaluating four launch grant round family-focused projects, this programme of work was led by Professor Joanna R Adler as Principal Investigator, with Dr Tim McSweeney, Dr David Wellsted, and Professor Brian Littlechild as Co-Investigators. Dr Rosemary Davidson assisted during pilot fieldwork. Dr Caroline Cresswell also joined the team during the pilot evaluation, leading on qualitative analyses of fieldwork thereafter. Natalie Hall and Amanda Busby from UH's Centre for Health Services and Clinical Research facilitated training for the project in the use of REDCap, oversaw processes to enable data capture, and conducted analysis of YEF's core measures data – collected by the project staff, using this software.

If you notice inaccuracies in this document, please report them back to Professor Joanna R Adler: J.R.Adler@herts.ac.uk

List of Abbreviations

ACE	Adverse Childhood Experiences
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CRIES-8	Children's Revised Impact of Events Scale-Eight item
DSA	Data Sharing Agreement
ESYTC	Edinburgh Study of Youth Transitions (sweep 3 measure used)
GDPR	General Data Protection Regulation
GYM	Guiding Young Minds
IES-R	Impact of Events Scale-Revised
NICE	National Institute for Health and Care Excellence
PTSD	Post-Traumatic Stress Disorder
REDCap	Research Evaluation Data Capture system
SCORE 15	SCORE 15 Index of Family Functioning and Change
TIC/A	Trauma-Informed Care/Approach
SDQ	Strengths and Difficulties Questionnaire
UH	University of Hertfordshire
YEF	Youth Endowment Fund

Executive summary

The project

The Guiding Young Minds (GYM) programme aims to support young people with experience of trauma to improve potentially challenging behaviour, establish a vision of a positive future, and set personal goals. In the long term, GYM aims to reduce gang involvement, anti-social behaviour, and violence. Delivered by ASSIST Trauma Care, the intervention lasts between six and 12 months, depending on the young person's need. GYM then has an 'open door' policy for young people to reach back for help when required. GYM provides intensive mentoring (delivered by mentors with lived experience) and trauma-informed therapeutic support to young people identified as frequently truanting, at risk of gang membership, exposed to adverse childhood experiences, or displaying high impulsivity and/or hyperactivity. Schools, social services, police, and youth offending services may refer young people, or they can self-refer after attending a GYM outreach event. Alongside mentoring, the therapeutic interventions are tailored to need. This includes one-to-one trauma-focused cognitive behavioural therapy and joint family therapy. In this project, ASSIST Trauma Care aimed to recruit 80–90 young people from Northamptonshire and Coventry to GYM.

YEF funded a feasibility and pilot evaluation of GYM. The feasibility study aimed to ascertain what factors supported or interfered with the successful delivery of the programmes and whether the intervention's recruitment, retention, and reach were feasible, and to understand service users' views and experiences of the intervention. Seventy-one children participated in the intervention during the feasibility phase, and 15 participants took part in interviews for the feasibility study (including four professionals, eight parents/carers, and three children). The pilot study then aimed to further describe the referral and screening process, assess retention, ascertain the readiness for a larger-scale evaluation, evaluate the implementation process, and assess the direction and magnitude of potential changes in child behaviour and family-functioning outcomes. An additional 20 young people were referred to the intervention during the pilot phase, which also considered longer-term outcomes for those young people who had been referred during the feasibility phase. Eighteen participants (including five young people, five adults with parental responsibility, and eight professionals) were interviewed for the pilot, while quantitative data for 74 young people were analysed. Data collected related to the delivery of the programme, demographic data, and some core measures (including the Strengths and Difficulties Questionnaire [SDQ], a measure of behaviour, and the SCORE 15 Index of Family Functioning and Change). The evaluation ran from February 2020–April 2022. The feasibility and pilot studies took place during the coronavirus pandemic, requiring both the delivery and evaluation teams to adapt to challenging circumstances.

Key conclusions
During the feasibility phase, the use of credible and relatable mentors was consistently identified as a strength. COVID-19 impacted service delivery in the feasibility phase, reducing the level and quality of engagement with children and their families. GYM practitioners responded flexibly, providing more virtual contact.
GYM's recruitment, retention, and reach were found to be feasible. In the feasibility phase, 98 children were referred to the programme, of whom 71 went on to engage. Eighty-nine per cent of those engaging with GYM were still in contact with the project by the end of the feasibility phase or had completed the programme and been discharged. The small number of children and parents/carers interviewed were overwhelmingly positive about GYM, praising the support provided by mentors.
The pilot study found that the referral and screening processes worked appropriately, with little risk of bias. Retention in the intervention was also very high during the pilot phase, with 93% of enrolled families continuing to participate after 12 months. While programme retention was high, completion of core measures was poor, with less than a third of the families that completed measures at baseline completing them 12 months later.
In the pilot phase, the evaluator found that GYM was broadly implemented as intended (despite changes made due to COVID-19). The degree of personalisation of the approach, particularly the open-ended mentoring, may make it difficult to ascertain the 'dosage' of the intervention in future evaluations.

The evaluator judges that GYM has the potential to be evaluated in a large randomised controlled trial. However, several challenges would first need to be resolved, such as whether data collection can be improved.

Interpretation

In the feasibility phase, the use of credible and relatable mentors was a consistently identified strength of GYM. Interviewees described good working relationships with GYM and expressed a considerable amount of respect, admiration, and appreciation for the work delivered by the project. COVID-19 and social distancing measures did impact service delivery during the feasibility phase and reduced the level and quality of engagement with children and their families. The GYM team responded flexibly and constructively to these restrictions, implementing a virtual service and increasing the use of social media to engage young people.

GYM's recruitment, retention, and reach were found to be feasible. In the feasibility phase, 98 children were referred to the programme, of whom 71 went on to engage. Those young people targeted by GYM were regarded as being largely neglected or overlooked by local services. At the point of engagement with GYM, families could often be found in a state of crisis and in urgent need of support for their children. Trauma, crime, and violence were consistently reported features of many GYM service users' lives.

Eighty-nine per cent of those engaging with GYM were still in contact with the project by the end of the feasibility phase or had completed the programme and been discharged. The small number of children and parents/carers interviewed were overwhelmingly positive about GYM, reporting superb support provided by mentors. Some parents observed how their children had become better at managing and controlling their emotions because of contact with GYM and its therapeutic support and suggested that children now responded more appropriately to negative or dangerous encounters. Some parents expressed concern and anxiety about the scope for a relapse to past behaviours once GYM support ended.

The pilot study found that the referral and screening processes worked appropriately. For the majority of the referred young people, the child was 12 years old, predominantly male (90%) and white (66%) or mixed race (21%). Most referrals came from police and schools. For some young people, the time between referral and engagement was rapid; for others, it could take longer, something mainly attributed to lockdown periods and school closures. It appears that there is very little risk of bias in the referral and screening process.

Retention in the intervention during the pilot phase was very high, with 93% (69/74) of enrolled families continuing to participate after 12 months. While programme retention was high, measure completion was not (with less than a third of the families that provided data at baseline providing data 12 months later). Data collection was compromised both by COVID-19 and by therapeutic decisions made about pursuing measure completion. Where data were collected from the core measures, there were improvements in reported behaviour and family functioning-related outcomes. However, without a counterfactual group that did not receive GYM, we are unable to be confident that positive changes were solely attributable to the programme.

In the pilot phase, the evaluator found that GYM was broadly implemented as intended (despite changes made due to COVID-19). ASSIST Trauma Care consistently provided mentoring and therapeutic support, both of which were generally well received by referrers and young people. The degree of personalisation of the approach, particularly the open-ended mentoring, may make it difficult to ascertain the 'dosage' of the intervention in future evaluations.

The evaluator judges that GYM has the potential to be evaluated in a large randomised controlled trial. However, several challenges would first need to be resolved, such as whether data collection can be improved, whether the current programme would be able to increase capacity, and whether a suitable control condition could be identified.

YEF has opted not to proceed with further evaluation of ASSIST at this stage.

Introduction

Background

ASSIST Trauma Care is a not-for-profit organisation employing experienced specialists trained to work with post-traumatic stress disorder (PTSD) and the effects of trauma in line with NICE guidelines. Their stated mission is to support young people in their journey from 'trauma to recovery'. ASSIST consists of specialist therapeutic and gang-related interventions incorporating trauma-focused cognitive behaviour therapy and receives referrals from schools and police in Northamptonshire and Coventry. The current NICE guidance (pathways.nice.org.uk) indicates the use of cognitive behavioural therapy (CBT)-related interventions in young people with identified PTSD, typically within two to three months of onset.

This report incorporates feasibility analysis alongside a pilot evaluation to consider process and before and after outcomes for Guiding Young Minds (GYM). The GYM intervention provides a holistic intervention with an emphasis on supporting young people in the context of their respective family circumstances, akin to a wraparound approach. The wraparound approach was developed in the USA. A consensus statement on its operating principles was reached by the National Wraparound Initiative (Bruns and Walkers 2008). The main principles centre on working in a family-centred, community-embedded way within multi-faceted, culturally aware teams. Wraparound has been shown to be promising and/or effective by Washington State Institute for Public Policy (2020).

The intervention for each young person usually lasted between six and 12 months. This goes beyond the typical six to 12 sessions outlined under the NICE pathway and reflects young people's experiences of more complex, developmental trauma. Working in a trauma-informed manner has become increasingly prevalent, particularly in relation to trauma and adverse childhood experiences (ACE) (CDC 2020), with several police and crime commissioners encouraging such approaches. In Northamptonshire, there is a dedicated ACE team that has been driving forward work since at least 2016 (Paterson 2017). What a trauma-informed approach (TIA) means may vary, but a useful way to conceptualise it and the principles at the heart of most trauma-informed practice are usefully (and accessibly) summarised by the University of Buffalo Institute on Trauma and Trauma Informed Care (TIC) (2019). Essentially, rather than providing services to treat one or more particular aspects of trauma, TIA seeks to be engaging and accessible, thus intending to avoid worsening trauma by not acting in ways that would be harmful (University of Buffalo 2019). However, variance in how TIC or TIA are enacted reflects one of the challenges noted by NICE, which concluded that: "*There is very little evidence demonstrating measurable impact of TIC or TIA. The evidence that does exist is of a low quality and come(s) almost exclusively from the US*" (NICE Guideline NG116, 2018, p.149). One year later, the Long-Term Plan for the NHS clearly advocated TIA in the care and support of young people in the health and justice system (point 12, p.118, NHS England 2019). Despite this recommendation, there is still limited systematic evaluation of trauma-informed care (Asmussen et al. 2022).

GYM also includes intensive mentoring. There is some evidence that mentoring can be effective as an early intervention (Joliffe and Farrington 2008). The national evaluation of the Youth Justice Board Mentoring Schemes did not find a reduction in offending. However, one of the recommendations resulting from this evaluation was that delivering mentoring to young age groups at risk of offending may be more effective (St James-Roberts et al. 2005). The strength of the mentoring relationship seems to be critical in reducing reoffending. An international meta-analysis (Tolan et al. 2013) found stronger effects when mentoring meetings were in depth and frequent and where emotional support was emphasised. More equivocal findings have been noted where mentoring relationships break down (Tarling et al. 2004). A more recent

meta-analysis of generalised mentoring programmes (not just focused on reducing offending) explored potential moderator effects and indicated that where mentors are drawn from 'helping professions', mentoring relationships are more likely to be associated with greater positive outcomes (Raposa et al. 2019), concluding that "*youth mentoring programs remain a moderately effective intervention for youth at-risk for a range of psychosocial and academic problems across diverse outcome domains"* (p.440).

Intervention

For the purposes of this evaluation, the engagement strategy of ASSIST needs to be noted as being for two discrete groups: By far, the largest number of young people, families, and professionals that work with them do so during outreach activities. This is mainly drama and workshop, group-based activity that can be thought of as universal in delivery for the target population selected. For the purposes of the YEF evaluation, the outreach work is considered as a way to recruit potential participants into GYM, which is the more in-depth, targeted, trauma-informed CBT intervention. At evaluation inception, ASSIST informed us that approximately 10% of those taking part in outreach approach them for one-to-one work. As part of this evaluation, the pilot phase explored referrals in more depth, including considering self-referrals.

The expectation from ASSIST was that approximately 80–90 people would engage with GYM over the first two months. For each young person, they allow intervention of between six and 12 months. This rate is ambitious, but they have previously scaled up from a local to national delivery in other areas and had a good sense both of need and their capacity to deliver.

Another necessary consideration related to the independence of their sample from other interventions. In common with other such programmes, it is likely that several of the GYM clients were also engaged with social services, housing services, and/or youth offending services. At the outset of this evaluation, it was noted that the young people based in Northampton may also have engaged with the Community Initiative to Reduce Violence. The evaluation team was concerned that this might present a particularly close potential confound to understanding the efficacy of GYM. During the feasibility phase, it became apparent that ASSIST was not recording any referrals from the CRIV. This was due to an agreement between the teams that GYM intervention would take precedence, thereby removing the risk of confound from this phase of evaluation.

Referral process

Referrals are received primarily from schools but also from police, as described below.

Screening

All referrals are screened for suitability by ASSIST staff using a set of bespoke tools developed for this task.

Participant inclusion criteria

GYM's referral criteria include those young people identified as frequently truanting, at risk of gang membership, exposed to an adverse childhood experience, or displaying high impulsivity and/or hyperactivity. If a young person presented with common mental health challenges, such as depression or anxiety, then they were accepted into the programme, but potential clients with severe conditions were not accepted. The referring criteria were implemented without fixed thresholds and were intended as a guide for schools and other referrers. Criteria were assessed initially by the referring agency (largely based on their knowledge of the child and their circumstances) and then screened by GYM staff. Please note that although frequently working with young people who would have been known to and potentially working with other

agencies, such as the youth offending service or social services, ASSIST did not work with young people who were concurrently receiving therapeutic interventions elsewhere; asking someone to engage in potentially competing psychological approaches would be unethical.

Exclusion criteria

Not meeting inclusion/referral criteria outlined above and/or presenting with mental health challenges that were more severe, such as psychosis

Sample size

Feasibility: 15 qualitative interviews and quantitative data from 98 initial referrals

Pilot: 18 qualitative interviews and quantitative data from 118 initial referrals

Recruitment and follow-up

Following recruitment into the programme (t0), the clients were followed up at: three (t1), six (t2), nine (t3), 12 (t4), 15 (t5), and 18 months (t6).

Aims and objectives of the evaluation

The overall aim for the feasibility and pilot evaluations was to investigate GYM's potential to improve children's and young people's outcomes. The GYM evaluation commenced with a feasibility phase, then progressed to a before-after pilot study, carrying through quantitative data from feasibility. The evaluation uses a cohort design to assess change over time in main outcomes and success of delivery. A further aim is to determine whether it will be possible to deliver a large-scale evaluation of the intervention. The outcomes listed below cover problem behaviour, emotions, trauma, family functioning, and engagement in criminal behaviour.

ASSIST evaluation objectives

The overall objective is to assess whether there is improvement in emotion, problem behaviour, and family functioning; distress related to trauma; and reduction in engagement in criminal behaviour by the children involved in the programme. Specific objectives are:

- To assess the potential effect size of the GYM intervention, evaluated across the project's routine measures and those specified by YEF
- To evaluate progress in achieving goals set as part of the GYM programme
- To evaluate the methods for recruiting clients from the intervention's target population and retaining clients in the programme once enrolled
- To evaluate the potential to deliver a larger scale, randomised trial.

Core measures

As part of the inception and feasibility phase, YEF specified a standard set of measures to be used and compared across a range of commissioned interventions and evaluations. This is referred to as the core measures dataset and is described in more detail in the data collection section below. First, we summarise the broad approach.

Primary outcomes

Psychological well-being, emotional, and behavioural measures:

- Strength and Difficulties Questionnaire (SDQ, Goodman 1997)
- SCORE 15 Index of Family Functioning and Change (Stratton et al. 2014)
- The Impact of Events Scale (IES, Weiss 2007) and the Children's Revised Impact of Events Scale-Eight Items (CRIES-8, Perrin et al. 2005)
- Edinburgh Study of Youth Transitions and Crime (ESYTC) – sweep 3 (McVie 2007)

Adherence to intervention

- Adherence to the intervention was assessed by recording attendance at therapeutic interventions and monitoring additional, relevant information provided within follow-up assessments, including wraparound appointments.

Service-user experience

Qualitative interviews were conducted with young people and those who had parental responsibility for them to investigate their experiences of the intervention. Similar interviews were conducted with service providers, referrers, and stakeholders. Qualitative interviews allow an exploration of rich, in-depth information about interviewees' perceptions of ASSIST GYM, but it is difficult to generalise from the findings. This could be noted as an evaluation limitation as experiences reported may not be relevant to, nor representative of, all stakeholders and service users involved with the project during either phase of the evaluation.

ASSIST-specific outcomes

- GYM uses goal setting as a therapeutic method, and progress on the goals form an additional outcome for this programme.
- ASSIST has also articulated a range of longer-term outcomes linked to a cessation of gang involvement, carrying knives, violence, and anti-social behaviour. These outcomes are outlined in the Logic Model below (Figure 1), but most are beyond the scope of the evaluation.

Ethical review

The University's ethics and integrity policies and processes can be seen at: https://www.herts.ac.uk/research/research-management/ethics-and-research-integrity. In accordance with this process, the evaluation had full approval from the UH Health, Science, Engineering and Technology Ethics Committee (protocol numbers: LMS/SF/UH/04101-feasibility and LMS/SF/UH/04697-pilot). Following COVID-19 and changes in the initial deadlines for both phases of this evaluation, amendments were resubmitted for further extensions. Data collation was eventually permitted until November 2022, under approval 04697 (see appendix A).

Safeguarding

The same process was adopted for feasibility and pilot studies: interview participants were made aware that there may have been situations, under the safeguarding framework, where there could have been a statutory obligation for members of the evaluation team to break confidentiality and provide information

back to the organisation providing the intervention or other statutory bodies. Although it was made clear that the evaluation team would not process identifiable data, participants needed to be clear that for safeguarding reasons, anonymisation was not complete.

The initial intention was that evaluators would be following the safeguarding protocols provided by ASSIST, working in close liaison with GYM project managers. Given the developments and dramatic changes to policy and process developed during the pandemic, the evaluators further developed our overarching practice, working in continued consultation with project managers. No safeguarding concerns arose during fieldwork and none were found in the dataset (beyond those for which young people had initially been referred).

Consent

The information in this section pertains to both the feasibility and pilot evaluation. Most of the administrative data being collated for this evaluation were shared, stored, and processed under the principles of legitimate interest. Additionally, there were interviews undertaken (with service users, stakeholders, and service providers) that proceeded on the basis of legitimate interest, supplemented by informed consent. When providing information and gaining consent from young people, a multi-stage process was designed to ensure that those with parental responsibility for the young person would be informed first. If they provided consent, then the team would contact the young person, who would then be presented with age-appropriate participant information and offered the opportunity to participate (which they could refuse). Evaluators were mindful that in some circumstances, parental interests could have conflicted with young people's rights. In such circumstances, the children's interests would have been prioritised.

When being invited to participate in interviews specifically for the evaluation, all prospective participants were provided with an information sheet and given time to read it fully before any interview. Any questions were satisfactorily answered, and if the participant was willing to participate, either written informed consent was obtained prior to the interview or verbal consent was obtained and recorded as part of an online interview process. During the consent process, it was made completely and unambiguously clear that the participant was free to refuse to participate in all or any aspect of the evaluation, at any time and for any reason, without incurring any penalty or affecting their continued involvement in the intervention. Information was provided in accessible, age, and cognitively appropriate ways; consent was treated as an ongoing process; consent and participation could be withdrawn without penalty; findings and data are anonymous where possible, confidential throughout and, where appropriate, depersonalised or anonymised according to principles both of the General Data Protection Regulations (GDPR) and UK anonymisation network framework. Please see appendices B and D.

Data protection

The legitimate interest under which much of this evaluation proceeded rested on the fact that the intervention (and thus evaluation) seeks to ascertain whether or not there might be a public benefit from the potential reduction in harm to/from the young people, their families, and wider communities. As data processors of the routine monitoring data and controllers of the bespoke (interview) data, UH was (and is) registered and fully compliant with the requirements of the GDPR (Regulation (EU) 2016/679) and the Data Protection Act 2018. The UH Cyber Essentials Certificate number is IASME-A-09513. This research was conducted in accordance with an agreed Memorandum of Understanding (MoU) and Data Sharing Agreement (DSA), which were informed by a comprehensive Data Protection Impact Assessment. These

were all agreed upon between the grantee and evaluators, where possible, drawing on YEF general principles as they developed.

Data transfer to the evaluator was in pseudonymised form and compliant with the DSA. Data storage was on secure servers. Access to the evaluation database was and is controlled and administered by UH Data Management, and access is via end-to-end encryption. The servers are protected by firewalls and anti-virus products and are patched and maintained (including back-ups) according to best practice.

The pseudonymised evaluation data will be electronically archived on secure servers for five years after the final evaluation reports have been completed. Access to the data will continue to be managed and only made available to members of the evaluation team, to YEF personnel, or, where necessary, for statutory regulatory processes. Privacy notices and information about the routine monitoring data were provided by the grantee to their beneficiaries/service users.

Confidentiality

All data captured in the survey database remain anonymous to the evaluation team. Pseudo anonymity was achieved by providing each client with a randomly generated study ID that was used in the dataset and unrelated to their personal details. All reporting only provides summary data, which avoids the potential to identify individual clients. Where quotes are included from qualitative interviews, any identifying material has been removed or modified as appropriate.

By using a random ID to protect the identity of the beneficiaries and service users, the GYM team could provide the data required for the evaluation while maintaining a level of protection against disclosing the clients' identities. A relatively routine way to do this was adopted, which is for the intervention team to retain a key that allows identification of the clients from the random code. If subsequent data linkage had been possible, then this key would also have allowed longer-term follow-up from public and institutional databases. Subsequent data linkage had originally been seen as desirable. However, it should be noted that grantees were commissioned and began running their interventions before privacy notices and data protection implications of potential archiving had been fully worked through within the YEF. As such, the grantee's initial agreements with referrers and with clients did not make it clear that data might have been used in that way. Accordingly, it was agreed that if found suitable for a full trial, this intervention would need to adopt different principles and that, from the evaluation perspective, this study will not be moving into an internal randomised control trial (where data might have been carried forward). This means that there will be no need to unmask the data because it will not be deposited in YEF's data archive.

Quality assurance

Evaluation staff reviewed data for errors and missing key data points at regular intervals and via two specified data audits. The pilot evaluation database was also programmed to generate reports on errors and error rates. Essential study issues, events, and outputs, including defined key data points, were monitored and documented.

Feasibility study

Overview

Research questions

The key questions for the feasibility study were to better understand:

1. The factors that support or interfere with the project's successful delivery
2. The feasibility of the project's recruitment, retention, and reach
3. Service users' experiences and views of the intervention.

Success criteria and/or targets

A key focus for the feasibility phase of the evaluation was to assess the extent to which the project was on target to achieve its intended recruitment targets and the extent to which it was reliably using the core measures designed to facilitate assessment of change over time (see core measures below). ASSIST intended that there would be 250 initial outreach engagements with young people per annum, leading to 30 young people who would engage with the GYM targeted intervention during the two years of YEF funding. Please see the Intervention section above for an outline of the GYM aims and objectives.

Methods

Participant selection

For quantitative data, it was intended that the entire cohort would have been analysed. For qualitative aspects of this evaluation, sampling was purposive for professionals and largely intended to be opportunistic for child and adult interviewees, using the GYM staff as gatekeepers. Interviews were conducted with 15 interviewees: four professional stakeholders, eight parents/carers, and three children. Professional stakeholders were sampled purposively to capture management, practitioner, and provider perspectives on how the interventions had been implemented, developed, and delivered. The project acted as a gatekeeper for access to parents/carers and child interviewees. Each adult who had agreed with their worker to be approached was contacted up to three times before being dropped from further contact by the evaluators.

Theory of Change/logic model development

The Theory of Change was developed by the project at the time of applying for funding from YEF. The underpinning theories relate to how a holistic approach may help young people, alongside their families, to respond to trauma and ultimately become less entangled in violent and/or anti-social behaviours while concomitantly reducing children's risk of being exploited. Figure 1 summarises a logic model that was refined with the evaluation team during the feasibility phase. Inputs and outputs were tested during feasibility and pilot phases of the evaluation. Shorter-term outcomes were assessed during the pilot phase. Mid-/long-term outcomes are beyond the timeline of this evaluation. It should be noted that several of the longer-term outcomes would not be applicable to all young people within the GYM intervention. This is because of the wide inclusion criteria. Where relevant, early progress towards goals was noted in comments fields of the survey database. It should also be noted that the 'dosage' and 'duration' of the intervention could be varied as it was intended that any one young person may be supported for between six and 12 months.

Figure 1. Logic Model: The ASSIST Trauma Care – GYM project

Problem statement	To provide mentors with lived experience and specialist therapy to support young people involved in or at risk of becoming involved in knife crime and/or serious violence and help them to successfully choose a more positive future.		
Inputs	**Outputs**	**Short-term outcomes**	**Mid-/long-term outcomes**
• Intensive mentoring from mentors with lived experience. • Specialist trauma therapy for ACEs. • Group presentations and workshops. • Assertive outreach, including sports/activities. • Input and interaction via social media (e.g. *Post Code* and *The Life* films).	Mentors establish positive relationships with project participants. Mentors serve as role models. Trauma-informed therapy delivered. Families/carers involved as appropriate. Working in partnership with schools and other referral agencies as appropriate.	Improvements (as measured using YEF's core measures) observed in relation to: • Any emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behaviour (SDQ) • Quality of family life (SCORE 15) • Levels of distress experienced due to traumatic events (IES-R and/or CRIES 8) • Self-reported delinquency (ESYTC). Other short-term outcomes include: • Establishing a vision of a positive future • Setting of personal goals.	Improved educational outcomes (e.g. reduced levels of truancy and exclusions, improved educational attainment). Improved offending outcomes[1]: • Cease gang involvement • No longer carry knives • No further involvement in violence • Cease anti-social behaviour
Impact	Transform educational and offending outcomes for project participants.		

[1] Progress in some of these areas were monitored by the project using input from police and self-report from young people, parents, and schools (as appropriate) upon completion of the project and captured in case notes provided within the study's database.

Data collection

The ASSIST GYM evaluation draws upon different data sources and methods. These were designed to include the use of routine monitoring data collected by GYM staff, core measures specified by YEF, and qualitative findings from interviews. To better understand the ways in which GYM was intended to operate, evaluators also planned to run a workshop. This was initially intended to be for all four grantees being evaluated by this team to share and develop learning during inception. Due to scheduling challenges and the onset of the COVID-19 pandemic, the combined workshop changed to a series of meetings and exchanges of materials between the evaluator and each grantee, with no cross-grantee sharing.

Interview protocols were designed to facilitate qualitative data collection from young people, those with parental responsibility for referred young people, and professionals, including referrers. The interview protocols can be seen in appendix B. They focused on understanding the implementation process, including factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention, and reach; young people and parent/carers' experiences and views of the intervention; and practitioner and provider perspectives on how the interventions had been implemented, developed, and delivered.

Quantitative data were collated by the grantee and then uploaded via REDCap; this is the web-based Research Evaluation Data Capture system. It is both a secure system and one that is relatively straightforward to learn how to use when entering data. Descriptive statistics have been used for feasibility evaluation and inferential analyses conducted within the pilot phase.

It should be noted that the GYM intervention and its evaluation were conducted under atypical circumstances. Commissioned in 2019 as part of the initial launch round of YEF grants, intervention delivery was adversely affected by the first waves of the COVID-19 pandemic. Similarly, evaluators responded to COVID-19 lockdowns, infections, requirements for remote, then hybrid working, and implications for interviews (moving more fully to online than had been initially intended). Lastly, it should be noted that both evaluators and grantees needed to be responsive to emerging practices and changes from the commissioner, as YEF project management and evaluation teams formed, articulated, and revised policies, guidance, and reporting requirements. Please see Findings: Impact of COVID-19 for additional consideration of the ways in which the pandemic affected GYM delivery and evaluation.

Data collection methods

All interviews were conducted remotely (either by phone or online). With participant consent (and for child interviewees, consent from those with parental responsibility), interviews were recorded for the purposes of transcription. Fieldwork for the feasibility study was undertaken between December 2020 and July 2021.

The majority of quantitative data collected comprise either data routinely collected within the GYM programme or the specified YEF core dataset. As far as possible, all identified data were collated by direct online entry to the REDCap system by members of the grantee team and stored securely on university servers. GYM staff received training on data collection and use of the REDCap online system from the evaluation team.

Data collection, data entry, and queries raised by a member of the grantee team were conducted in line with the data management processes as agreed between the grantees and the evaluation team. Data were routinely collected during the referral and screening process (as agreed with ASSIST). Once clients had been accepted onto the intervention, the agreed core data were collected (t0), and follow-ups with the clients were indicated at three (t1), six (t2) and nine (t3) months. (Feasibility data were carried through to pilot, where possible, allowing data collection to be extended to 12 (t4), 15 (t5) and 18 (t6) months).

Evaluation data

Routine monitoring data

The evaluation comprises an analysis of aggregated and anonymised data collected by intervention staff relating to information about referrals to the service, the screening and assessment processes, and any formalised reviews. These data were also intended to enable the profile of the source population to be characterised. By monitoring referrals, the evaluation team hoped to assess whether appropriate referrals were being made (as measured against the referral criteria) and the extent to which selection bias may have occurred in accepting clients into the programme.

Key demographic data

As intended, the intervention team captured key client-specific and demographic data, including age, ethnic heritage, gender, relationship to other ASSIST clients, and index of deprivation.

Core measures

The measures listed below were agreed upon by the grantees, evaluators, and YEF. Some had been suggested by this evaluation team in the original response to tender, and others that had been suggested were rejected in preference to those that could be adopted/had already been adopted across other YEF commissioned evaluations. Table 1 summarises the core measures.

Table 1. Measures considered for the evaluation

Measure	Purpose	Completed By:
Strengths and Difficulties Questionnaire, SDQ, (Goodman 1997)	Evaluates anti-social or other behaviour problems	Adult with parental responsibility, young person, and teachers
SCORE 15 Index of Family Functioning and Change (Stratton et al. 2014)*	Typically used to track progress towards desired outcomes in family interventions	Adult with parental responsibility and young person

The Impacts of Events Scale, Revised (IES-R) (Weiss, 2007)*	Self-report measure of trauma/PTSD that assesses the impact of identified stressful life events	Adult with parental responsibility
Children's Revised Impact of Event Scale – 8 (CRIES – 8) (Perrin et al. 2005)	Specifically designed for children and young people over eight years old, this also assesses the impact of stressful life events.	Young person
Edinburgh Study of Youth Transitions and Crime – sweep 3 (ESYTC) (McVie, 2007) [Young Person completed]	A 19-item, self-report measure to assess young people's involvement in anti-social, potentially criminal behaviours	Young person

* Measures that were not prioritised by the GYM intervention, in agreement with YEF project management.

Table 2 provides an overview of methods used in the feasibility study.

Table 2. Methods overview – feasibility

Research methods	Data collection methods	Participants/data sources (type, number)	Data analysis methods	Research questions addressed
Secondary analysis.	Routine monitoring data collected by GYM (including core measures)	Those referred, screened, and accepted onto GYM. Includes initial progress completing outcome measures	Descriptive statistics	RQ 1 & 2
Primary data collection.	Qualitative interviews	Purposive sampling of professional stakeholders and opportunistic sampling of parents/carers and/or children accessing GYM services	Thematic analysis	RQ 1, 2 & 3

Analysis

Monitoring data were audited and descriptive reports were generated that considered the following:

- Throughput — referral routes, acceptance and withdrawal/completion rates
- Screening — barriers and facilitators to acceptance on the programme
- Completeness of routine measure recording.

Qualitative interviews were analysed using deductive thematic analysis, with key themes derived from the three research questions articulated above.

Timeline

Table 3. Timeline

Date Completed	Activity
07.02.20	Evaluation workshops initially intended to be for all four grantees to share and develop learning during inception. This changed to a series of meetings and exchanges of materials between the evaluator and each grantee.
07.02.20	Ethics submission and finalised feasibility plan.
17.03.21	Database set-up and REDCap training completed.
17.03.21	Feasibility data audit.
16.12.21	Data sharing protocol renegotiation and transition to before-after pilot.
16.12.21	Completion of feasibility analysis and preparation of slide stack (amended by YEF to delivery of draft feasibility reports).
28.02.22	Production of summary feasibility findings for ASSIST.

Please note that all dates in this timeline refer to the last point at which activity was completed, in line with milestone payments. Also, that data captured in the feasibility phase went beyond the initial audit.

Findings

Participants

Quantitative cohort: Research questions 1 & 2

By 16 July 2021, 98 children had been referred to GYM, of whom 71 (72%) went on to engage with the project. Twenty-seven referrals were not accepted. The main reasons for non-acceptance included:

- the child refusing the offer of support (16)
- failing to meet the project's criteria (8)
- falling outside the age range set by YEF's funding criteria (2) or
- living out-of-area (1).

Further information on the feasibility cohort can be seen in appendix C. Table 4 shows how many people initially agreed to take part in interviews by the evaluation team and the numbers eventually completed.

Table 4. Qualitative interviews: Research questions 1, 2, & 3

Group	Consents received (via ASSIST)	Interviews achieved
Adult (parent/carer)	11	8
Child	8	3
Professional stakeholder	6	4
Total	24	15

The conversion rate of initial consents received to interviews achieved was lowest for the young people. This is not entirely surprising and may reflect several interrelated challenges. First, gaining access to young people was, deliberately, a multistage process where consent to contact them needed to pass through not just ASSIST but adults with parental responsibility as well. Second, the young people at the centre of these referrals were vulnerable and may have been particularly circumspect about engaging in research. Also, the evaluation team was conducting interviews in the middle of a global pandemic when young people were at heightened risk and experiencing additional challenges to their mental and physical well-being. More prosaically, between initially saying it would be all right to take part and being approached to schedule an interview, any participant could change their mind or find that competing demands were too great. One way to ameliorate the potential perceived pressure of an interview might have been to have offered a short survey to have been completed on a phone or other digital device at a person's convenience. That, too, would have potential limitations, such as variable digital access, and would have meant adding another data request that may have felt remote.

Intervention feasibility

Referral, screening, and engagement

During the feasibility phase, GYM reported running over 20 workshops for more than 3,500 pupils from 19 schools across the Northamptonshire and Coventry areas.

Most of those engaging with GYM's services accessed mentoring (63), and two-thirds (47) were still receiving support from GYM by the end of the feasibility phase. Around one in ten dropped out of contact with the project following initial engagement (8), while more than one in five (16) completed and were discharged.

Available data indicated that those children engaging with GYM services during the feasibility phase had been referred by the police (26), local schools (23),[2] the Early Intervention Service (10), children's services (2), the youth offending service (1) and the Family Hub (1).

Stakeholder perspectives

Referral, assessment, and initial engagement

Since its inception in 2018, ASSIST has reportedly worked with over 110 primary schools and more than 50 secondary schools across Northamptonshire and Coventry, delivering more than 800 school assemblies and workshops in a two-year period. Schools were a key focal point for the intervention, as children were considered to feel safer there, and this is the environment where they may be more receptive to messaging and learning. The initial interaction with schools during the feasibility phase was focused on better understanding their issues and concerns so that a more tailored intervention could be delivered. Though dealing with tough issues, the GYM team sought to ensure that interactions were light-hearted to encourage and promote engagement.

> *"It is supposed to be very nurturing…because we believe a child cannot change or be educated if it doesn't feel safe. So, what we say to the kids is it's called GYM… and if they don't want to tell their friends, and if they saw us with them, they would say, 'Oh, it's just someone from the gym', but we're* [training] *their mind, not their body"* (Stakeholder #3).

During the feasibility phase, referrals to the project were generated primarily via schools from Northamptonshire and Coventry and by the police. A key distinction identified between school and police referrals was that the former tended to be more focused on primary prevention (preventing violence before it happens), while the latter, which included children already known to the criminal justice system, might be considered more as a secondary form of prevention (responding to instances of violence). Some children were identified as being at risk by virtue of at least one parent (typically the father) being gang involved. This generated increased demand for GYM's services from the police. GYM reportedly had a long-standing working relationship with the police, enabling a good understanding of the project's referral criteria. This was, however, an ongoing process as new police areas were engaged and made aware of the support being offered.

The work of the project had also reportedly helped to facilitate improved communication between schools and the police regarding identifying and generating appropriate referrals. Given high levels of demand for the services offered by GYM, the project had received offers to pay for work with children falling outside the existing criteria in place for its YEF-funded work from parents, other charities, and local authorities.

> *"I think that's what we're going to have to do because the demand is getting so great and so many people are saying, 'Can we pay you?', including parents, to be honest…We're probably going to have*

[2] In total, 21 schools reportedly made 56 referrals involving between one and six referrals each, with an average of three (mode=1).

to take on an additional mentor, not funded by the YEF, to try and cover the additional needs" (Stakeholder #4).

A small number of self-referrals had arisen from children – typically generated through word-of-mouth endorsements – but these could present a range of practical issues when children requested confidentiality.

> *"So, the young person can say on the consent form, 'I'm happy for you to talk to a certain person, but not this one'… I mean, it obviously does depend because we've got to work within safeguarding rules and everything else"* (Stakeholder #4).

Referrals to GYM tended to spike around school holidays, when the most vulnerable children were at greatest risk. At peak demand, the project found itself having to introduce a waiting list. However, not all of those children held on a waiting list would have been assessed as suitable. The data audit showed that the time between referral and enrolment ranged from the same day to 175 days (an outlier case).

After referral, the initial assessment involved a discussion with the child, teacher, and parent/carer. This would draw on standardised tools, such as the SDQ. During the assessment process, it could be judged by project staff that the child was not willing or able to make the behavioural and attitudinal changes required. This lack of capacity or motivation to change would typically render them ineligible for the project. This, in turn, could be a source of frustration and disappointment for some referrers. In these instances, project staff underlined the importance of managing referrers' expectations about who the project can work with amid concerns about the potential for net widening and increasing numbers of inappropriate referrals, as some schools may (perhaps understandably) looked to make the most of the service and support on offer via GYM. One of the main issues associated with inappropriate referrals is often related to the (older) age of the child.

Assessments to determine suitability and need were described as a process, not an event. The time taken to complete this process could be impacted by factors such as social circumstances of the child and levels of trust. Building trust with the child and family was therefore seen as a key early task for GYM mentors and therapists. There would be additional trauma-focused assessments for counselling support following a referral, typically conducted by a GYM mentor.

> *"Once you establish a therapeutic bond and a trusting relationship, then you sort of become part of their life, and they need to see you and talk to you, as therapists, or youth mentors"* (Stakeholder #1).

The assessment process allowed GYM to develop a more rounded picture of the social circumstances of the child and their family environment. This process helped the project to identify complexity within households (such as involvement of social services or siblings also affected by gang-related activity). As part of the assessment process, an initial call was made to the family to introduce them to the project in greater detail, outline what participation involved for children, and gather relevant information relating to the family's circumstances. It was noted that a small proportion of parents were criminally active and consequently less willing to engage with the service.

Finding time to work with some children during a busy school and assessment schedule (e.g. when preparing for exams) could sometimes be a challenge to securing initial engagement with GYM. Past negative experiences with support services also served as a potential barrier to engagement. Stigma, a lack of

awareness or recognition of the problems being faced, and excessive waiting times when seeking mainstream support were also identified as potential barriers. Facing issues likely to be raised during the counselling process could clearly be daunting for some participants, who may have been addressing these for the first time. For example, cases of child sexual abuse had been disclosed and uncovered during therapy sessions.

Interventions and support delivered

Families could often be found in a state of crisis and in urgent need of support at the point of child engagement with GYM; as emphasised by Stakeholder #3: "*They can be quite panicked, and they are looking for a saviour."* The focus of the one-to-one intervention was described as client-led and centred around the priority needs identified by the child. During initial encounters, practitioners highlighted the importance of being open, transparent, and realistic with children about what might be achieved. It was noted that the delivery of support was prioritised based on the levels of risk present within a given case, and the aim often was to instil a sense of hope and offer the child a viable alternative to the perceived allure of life in a gang – something that could be challenging.

Concurrent support was available and offered to GYM participants via dedicated therapists who were allocated cases based on the nature of presenting traumas. There was scope for joint therapy sessions involving a non-threatening, non-violent, or non-aggressive parent or carer (typically the mother). While family therapy sessions had been offered – and, according to interviewees, were often much needed – the focus of the intervention during the feasibility phase centred around the needs of the child.

> *"We've also got therapists involved, not with every child, but for some young people. They're seeing a mentor and a therapist concurrently, so seeing two separate people in the week. We involve the therapist when it becomes clear that there is trauma"* (Stakeholder #4).

Mentors were assigned to cases based on their skills, experience and capacity to work with a child. The presenting needs of the child, including gender-specific and practical circumstances, were also important considerations.

> *"We'll speak about who could be the best or the right person for the child to respect and not see as a threat. So that's what we look at first, and then we look at those who've got past experience and could take that on and empathise with the kid. We'll then discuss that as a whole team, and then we'll see who feels comfortable doing that"* (Stakeholder #3).

Stakeholders underlined the importance of parents and carers being engaged so that any progress being made in school could be sustained and reinforced in the home setting. It was considered important that significant others – particularly male role models – were engaged in the process to reinforce messages that may better address the needs of the child. However, the absence of what might be considered a stable, pro-social male role model in many children's lives was common, while some home environments and family relationships could be experienced as 'toxic' and detrimental to the child's well-being. Furthermore, the project worked with a few females who were considered to have had significant vulnerabilities linked to child sexual exploitation and gangs.

Mentors and therapists sought to focus their attention on addressing children's concerns or anxieties. Sessions typically lasted up to an hour, but there was reportedly considerable flexibility around this, depending on the circumstances and needs at the time. There were numerous examples provided during interviews where mentors routinely went 'above and beyond' in offering responsive forms of intervention. In one case, a mentor had to respond constructively while being present at a child's family home during a police enforcement raid. This sort of advocacy helped to highlight to referrers, like the police, the level of credibility GYM's mentors had with families and communities. GYM also offered supplementary support to the work being undertaken by a range of referrers and other local agencies. As such, GYM would typically be working with a small subset of children considered by local agencies to be most at risk of criminal exploitation.

At the time of fieldwork, GYM mentors reportedly managed a caseload of around 16 children at any one time. Given the complex needs of many of the children and families being supported by the project, GYM staff sought – within resources – to be as open-ended as possible about things like contact time and the duration of the intervention. The project was keen to empower children by offering open-ended support.

> *"Q: Do you have to place a cap on the length of time that you can be intervening with a young person before you have to refer them on elsewhere?*
>
> *We haven't chosen to do that. Our aim in all of this is to get young people on to a different path…to move them forward. I mean, if they're not going to move forward, we pick that up very early. If they are, we'll work until we get some change because the whole point is to stop these kids going into society with more problems. So, you know…we're going to stick with the ones you've got until they've recovered"* (Stakeholder #4).

The approach to counselling used by GYM therapists, by contrast, served to dictate the frequency, or minimum requirements around levels of contact.

The absence of a healthy relationship with one or both parents was a common issue identified for several children engaging with GYM. Interviewees noted that the lack of ambition and support offered by some family members to encourage their children to pursue their goals, interests, and aspirations could increase the appeal and allure of gangs and heighten both frustration and propensity to violence. It was also considered important by interviewees to explore non-academic-based opportunities with those struggling in school settings, where they may be anxious or lack confidence and self-esteem.

Addiction was identified as an issue within some families – and to a lesser extent, the children themselves – which could mask deeper underlying issues and anxieties for the family unit. There was an emphasis throughout the project on building capacity and resilience within the family so they were better placed to meet challenges going forward.

> *"While we work with them, we find the key people in their families that can support them and who they look up to as well. So, when we've left, we've always said, 'Don't be afraid to come back', but you've also got this strong aura and family around you here. So use them as you would the service. So, you're keeping it in the family"* (Stakeholder #3).

Success was measured in terms of improved relationships between children and parents, individual behaviour change, and the potential for that change to impact positively on others.

> *"Our motto at GYM is 'You're never in too deep to make a change'. Our success rate is even if we change one child – we're done. Because one child could change a whole community if he's got an influence. Our results aren't figures really. It's bringing results to a child and a family"* (Stakeholder #3).

For other interviewees, a successful end to a GYM intervention could involve the child no longer having immediate ongoing needs or an appropriate onward referral being made to address longer term needs, with the school often remaining an important link.

Throughcare and aftercare support

Building the trust and confidence of children to disclose matters like drug use, offending behaviour, or being subjected to different forms of exploitation can take considerable time to develop and nurture. The risk of exploitation that some GYM clients were exposed to meant they were also at risk of being moved for safety reasons at short notice, which could be disruptive and, on occasion, undermine any progress made therapeutically. The GYM delivery model meant that different practitioners and roles could be introduced at appropriate stages, subject to the needs of the child. There was scope for GYM to facilitate onward referrals, post-intervention, but all participants were reportedly invited to recontact the project at any time in the future, if required. Post-intervention, GYM, therefore, operated an open-door policy that encouraged and invited children to reconnect for any advice or support that may have been needed in the future. Ensuring adequate throughcare and aftercare support, post-GYM, concerned some practitioners. Having formed therapeutic attachments with their clients, it was noted that some children seemed reluctant to sever these bonds and form new ones following onward referrals, post-completion of GYM. In these instances, schools could be important for providing throughcare and aftercare support.

> *"Most of these kids, they present themselves with insecure attachment. And somehow, they manage to form some attachment or bond with us, and they would like to keep in touch or stay connected to us, one way or another.*
>
> *Q: Are you able to do that?*
>
> *Well, not really. Not really…obviously, we can still keep in touch…and we've been trying to look for football clubs or connect some of them. But it's, well, most often I hear that, 'They don't understand us like you guys do'…The schools are a big help for us because they are very engaging, and they are willing to put in place some resources and support for those kids that we are working with. And, usually, we involve the school as well, so they know what's going on and what's happening, so they support us with whatever they can"* (Stakeholder #1).

It was noted by some interviewees that children may be reluctant to engage with statutory services post-GYM for varied reasons, including prior negative experiences of these services. In making onward referrals, it was considered important to ensure that the child was 'valued, appreciated and heard' by those services.

Implementing YEF's core measures

Practitioners described how they framed the formal review process and use of YEF's core measures to service users as a way of monitoring progress towards achieving goals, but also as tasks to be completed infrequently during the intervention. As part of the review process, practitioners would draw on the views and perspectives of others (including teachers and parents, carers or guardians) to triangulate these and form a more rounded view of progress. There was also evidence that teachers and parents/carers were reassured by generalised feedback from GYM staff and the opportunity for discussion in terms of where progress was being made and where work might be needed subsequently.

Initial expectations around bi-monthly reviews had been revised, and the gap between these extended in light of YEF's core measures. The review process towards the end of the feasibility phase integrated the full range of core measures at pre-defined intervals, supplemented and informed with input from children, their families, schools, and – where appropriate – the police. Despite best attempts from the intervention team, there could sometimes be delays in securing timely input from parents and schools to inform these formal progress reviews, which seemed to range in frequency between six and eight weeks or potentially longer.

Although potentially predictable, it is worth noting that there were also some considerable inconsistencies being identified in the degree to which instrument scores varied based on the responses provided by the child, family, and school.

> *"Sometimes, we look at the SDQ across the three responses. Sometimes, the child thinks they're absolutely fine. All comes out as average, normal, no problem. The school think they're horrendous, and the family also think they are. Other times, the child's coming out and saying, 'Actually, I'm really in a high category. My behaviour is really bad', and the parent is saying, 'No, they're not. They're perfectly normal'…. And then we get other times when there are all the problems that are apparent at home, but the school is not seeing any of them.. It's not straightforward as to which of those three forms comes out a higher and why"* (Stakeholder #4).

Where there were competing narratives from informants, practitioner judgement would normally need to be exercised in judging priorities. From an evaluation perspective, additional information was sometimes captured in the comments provided to the survey database. It should be noted that individual differences in how such measures are interpreted are a common challenge in designing and implementing standardised scales where there are multiple informants. Differences in informant reports of the same individual largely arise due to differences in perspective and in perception of the problems being reported. Interpretation of those differences can only be evaluated within a particular context.

Interviewees described how they had sought to engage children in the review process by making it a reflective dialogue and a positively reinforcing process focusing on any progress that had been made and established areas for potential future improvement. This was considered helpful in distinguishing between and prioritising more immediate versus longer-term aspirations and goals. Referral agencies also reported conducting termly review meetings involving services like GYM, schools, and the family. There was universal recognition of the importance of having at least one engaged parent to increase the chances of success.

An initial audit of the core measures collected by the project conducted in March 2021 showed that data relating to 51 children had been screened by the project and 33 enrolled cases had been uploaded to

REDCap. This included follow-up data collected using YEF's core measures at three (data recorded for nine out of 31 possible children), six (21 out of 29 possible children), nine (three out of 23 possible children), and 12 months (14 out of 19 possible children). The full findings from the audit can be found in appendix C. It should be noted that this audit was primarily intended to test whether the database was being used and to flag to evaluators where they may be challenges in moving forward to the pilot phase.

Service-user perspectives

How service users heard about and why they agreed to engage with the project

Typically, interviewees had been referred to GYM by schools, social services, or the youth offending service. The mother of one 13-year-old with mental health issues and a history of violence – including at school and against family members – explained how her son had been at significant risk of exploitation by a drug dealing gang and permanently excluded from school. This *"absolutely awful"* situation resulted in a referral to GYM by the youth offending service.

> *"*[Every] *time he came home and I said, 'I can't press charges. I've got to think of his future'. And I was the target, and my husband was powerless to do anything…I restrained him one day when he was brandishing a knife at me. I don't know how I managed it, and I managed to get the knife off him, and restrain him, while my mum called police. And he was like a zombie; he was really bad. And that was when the youth offending got involved with us, and we had a brilliant youth offending officer…for about 12 months, and then I think that's where* [the mentor] *and GYM came into the mix"* (Parent #2).

Another interviewee recalled how her 12-year-old son, who had learning difficulties and anger management issues (including violent outbursts at home) and was socially isolated, had been referred to GYM following a school exclusion and at a time when he was particularly vulnerable to exploitation by gangs. This parent went on to explain how her family had hit 'rock bottom' following the school exclusion and that the intervention from GYM had arrived at exactly the right time. Another mother described how concerns about involvement in gangs and crime had prompted a referral to GYM for her 14-year-old son. This parent recalled a prompt engagement with GYM following referral and sustained, prolonged contact.

> *"As soon as* [my son]*'s name popped up with different people, like the police and everything, they were like, right, we're going to get* [GYM mentor] *involved. And he got involved really quick; I think it was only a couple of months that they referred* [my son] *to* [GYM mentor]*"* (Parent #6).

The children interviewed during the feasibility phase had all been referred via their schools for support. These children described how they liked the idea of having someone independent to talk with in confidence about any issues and concerns.

> *"I had this therapist…and she was, like, just speaking about the deep stuff all the time…Then* [the GYM mentor] *came in, and then* [they] *got me a new therapist and helped me as well…with, like, my mental health"* (Child #3).

> *"I just had a breakdown in school, and they contacted them, so because they thought it would help…just talk, so having someone to talk to…I had people to talk to at school, but sometimes school goes back to your family"* (Child #1).

The mentorship available via GYM was an attractive feature of the intervention, as it appeared to offer some families the possibility of access to a positive, inspirational role model. In these instances, a key ambition or desire was sometimes concerned with helping to build the child's confidence and self-esteem and helping to address existing insecurities associated with the absence of an appropriate male role model. The lived experience of the GYM mentors was considered important for parents as it afforded them credibility and enabled them to more easily establish rapport with children, who often found the mentors to be relatable adults.

> *"[*When] *somebody like* [the GYM mentor] *approaches them, they are immediately at ease because he dresses in a certain way, speaks in a certain way. They know – they know for a fact they can recognise somebody that's been there and done that… He's got the credibility thing with the youngsters because they don't trust anybody…especially not social workers, police, all those kinds of people. They're already - they're on guard the minute they walk through the door"* (Parent #4).

Other interviewees recalled how they had appreciated the openness and honesty of the mentors and being inspired by their personal journeys – hoping these would also inspire their children. Some parents recalled having mixed feelings initially about the lived experiences of the mentors but quickly being won around.

> *"I was very, very sceptical: how are you going to put some ex-gang worker with a child that likes to cause trouble? I was very sceptical about it…And he was really - GYM is brilliant, genuinely, like, the support that they give to my children…*[my son] *really looks up to* [the GYM mentor]*, and he's really changed his ways, which is a lovely thing because he was a kid that wanted to go out and do nothing but cause trouble*" (Parent #3).

What support and assistance were being sought?

Parents described being grateful for the support offered by GYM and the opportunity to access it, as often there was limited alternative provision on offer. For some, the lockdown had hampered progress, stalling their access to timely support. GYM, therefore, filled an important gap for these families. It was noted by several parent interviewees that GYM mentors were committed, non-judgemental, and would go 'the extra mile' for their clients and families. Mentors' flexibility was apparent when some children and families had expressed a preference for home-based support, and GYM accommodated this with weekly face-to-face sessions instead of, or sometimes in addition to, school-based support.

For some of the most vulnerable children, sessions were conducted face-to-face, where conditions allowed, and in the family home. The initial sessions aimed to better understand issues for both the child and the family. Parents commented on how they liked and appreciated the open-ended nature of the intervention and the reassurance and flexibility this afforded them. Having someone to talk to and confide in outside the family unit was seen by some parents as important for enabling behaviour change. Interviewees described how they welcomed the – sometimes frank – advice and input from the GYM mentor on their situations and experiences.

> *"*[The GYM mentor] *has become a sort of a very welcome person in my house and somebody I'm at ease with. He can help me to rationalise my, probably sometimes, totally over-the-top reactions or thoughts…And he says how it is. And he has this brilliant way of just knowing, knowing what to do, how to do it, how to put it right…And he'll also tell* [my son]*, and he'll tell it how it is"* (Parent #2).

The ethos of GYM was appealing to parents, with its focus on developing children's strengths rather than dwelling on their potential weaknesses. This could include encouraging children to think about applying or transferring what would otherwise be considered anti-social entrepreneurial skills into more positive, pro-social ones. There was an acknowledgement from parents, too, that the support being offered by GYM was certainly not limited to the referred child but accessible to and relevant to the wider family. There was also recognition of the benefits of the peripatetic nature of the support being offered by GYM, which was particularly valued during periods of lockdown and social distancing. It was acknowledged that GYM was a limited resource with high demand for its services. Some parents continued to be reassured that the support being offered by GYM did not feel as if it were time constrained or limited to a set number of sessions.

> *"These children aren't doing what they're doing because nothing's happened to them in their life. Something has happened to them in their life to get them into that place. And so you can't just unpick that in a couple of sessions; that takes a long time"* (Parent #4).

What worked?

Stakeholder/professional perspectives

A perceived strength of the project was the deployment of mentors with lived experience who were considered credible and relatable by the client group (a point reinforced by service users). This credibility and ability to engage children included with those outside mainstream education who may be viewed by services as hard-to-reach. Referrers described a history of a good partnership with GYM and a considerable amount of respect and admiration for their work. Working with GYM had been a positive, thought-provoking experience. Interviewees referring to GYM described the *"incredible"* support offered by GYM's mentors, who had always put the needs of the child first.

> *"The mentors…they are generally incredible, like, there's nothing more they could do. Their approach is always that the child comes first, and I think this is why we work with GYM…because their value kind of is exactly the same as ours…this, for me, is really important because it does offer the support to those children and the relationships that they have with those young people is paramount to everything"* (Stakeholder #2).

There was evidence of effective joint working and liaising between mentors and therapists in relevant cases too.

> *"The mentor isn't always totally aware of all the trauma, but we do get signed confidentiality forms so that we can, you know, they can talk to each other, and they do work quite closely together. The mentor will let the therapists know there've been issues, you know…So we make sure that they're working together…because the whole idea is working as a team with a young person. It's not completely separate"* (Stakeholder #4).

Word-of-mouth endorsements and recommendations from schools and pupils were considered to have been important ways to spread knowledge of the GYM project. Stakeholder interviewees believed that focusing the intervention on children considered to be 'influencers' had been a useful way of enhancing the impact of the intervention. Affecting the attitudes or thinking behaviours of these 'influencers' could, in turn, affect the views of children in their wider friendship network.

One improvement and benefit realised through the GYM project highlighted by interviewees related to children being increasingly able to recognise, articulate, and discuss areas that may underpin their anxiety – which can sometimes include the relationship with their parents. These issues could be more readily resolved by encouraging parents to have more open and inclusive conversations involving their children in order to reduce their anxiety. The importance of helping families to better communicate with their children had been a key focus of work for GYM mentors. This required them to be able to build a relationship with the family, where open and frank discussions around some of the issues and challenges they faced could happen without confrontation.

> *"Parents don't see themselves as the main threat to the child making change, but they are because of what they have said or what they have done"* (Stakeholder #3).

The positive relationships developed with schools and the feedback received from many of them (see Box 1 below) were considered to be a testament to the way in which the GYM project had successfully engaged children and delivered positive outcomes for them.

Box 1: Examples of feedback provided by GYM from schools following delivery of their workshops

"The workshop was pitched at the right level and has made the children much more aware of the gang culture in their area. GYM has become our 'go to' service for support if we encounter problems" (Primary school #1).

"*Our pupils gained a real sense of what is happening right now in our community, how people can get caught up in it and what that means. We really want you to come back"* (Secondary school #1).

"*The children now have a better understanding of what happens in their own town, and that it's not just places like London"* (Primary school #2).

"We chose challenging children to be part of this workshop. They were initially reluctant to get involved, but it soon got them up on their feet and gave them something to think about. They now have a better understanding that it is never too late to change course and start making the right choices" (Secondary school #2).

"The workshop message was blunt but extremely effective. Hard-hitting lessons were addressed in a very contemporary manner, relevant and pertinent. Pupils are empowered to stand strong and do the right thing. [The school] *would highly recommend every school working with you"* (Primary school #3).

"Your talk really hit me and a lot of other people. You got into our heads and made us all realise how bad things can be. You being in it and actually experiencing things made us all listen more. Everyone wanted you guys for longer. Keep doing what you are doing. You will change many lives!" (Secondary School #3).

There were believed to be some immediate, important impacts being observed following the delivery of presentations by GYM in schools and other settings, including when these focused on the negative consequences associated with involvement in gangs and crime. Some young people had also reportedly become inspired by GYM to look towards a career in youth work to affect and potentially change the lives of others, something that was extremely rewarding for the GYM team:

> *"And, yeah, then we feel we really have accomplished something when we see that"* (Stakeholder #1).

The persistence of GYM staff was also noted in several ways, for example, in relation to the use of illicit substances, which were seen as a tool used by gangs to manipulate and control vulnerable young people. This willingness of GYM mentors to work in this way to engage children in diverse settings was recognised by referrers and partner agencies. It was seen as being particularly important since gangs were considered adept at 'coaching' children to be better able to 'throw services off the scent' and conceal the extent to which vulnerable children were being exploited by gangs.

> *"Because gangs know how to put intelligence into kids to make services back off from them and to speak as if they're out of it, but they're really deeply into it. And they've got the knowledge that makes the professionals say, 'He's okay', and they sign them off, but it's all wrong…We got a youth bus that goes out into the community so we can heal wounds and see kids before they even get referred to us, and then there's the ones that are high risk that we go to schools, and we ask teachers to bring to our attention"* (Stakeholder #3).

Service-user perspectives

All interviewees were positive about the support they had received from GYM and their experiences with the project. Some parents endorsed the timeliness and impact of the intervention, particularly in the context of families' interactions with other services.

> *"I had been in contact with CAMHS* [Child and Adolescent Mental Health Services] *since he was about seven. I've been* [in] *contact with other independent youth support services. I've been in contact with absolutely everybody, and nobody managed to get through to my family the way that GYM has. It's amazing!"* (Parent #3).

> *"I've been begging for years for her to have something, and only because of Guiding Young Minds was I able to get this put in place. I have been literally begging people for years, social services. We've been to CAMHS …I can't tell you why this has been different…Maybe it's just timing as well, that it was offered at the right time"* (Parent #4).

Other parents, because of contact with GYM and its therapeutic support, had observed how their children had become better at managing and controlling their emotions or had been encouraged to think about alternative responses to potentially negative or dangerous encounters. Parent #2 described during an interview how the GYM mentor had connected with her son in a way that no other practitioner or service had before while also offering them valuable support and encouragement.

> *"Sometimes, I think I need somebody just to tell me what to do: 'Do this, and trust me, it'll work out'. And I said, 'It won't, it won't', and he said, 'It will, it'll work out. But if it doesn't work out, we'll try something else'. That man is like my Guardian Angel"* (Parent #2).

So impressed by the *"amazing project"*, one interviewee had informed other parents about GYM, who had then taken up the support offered. There were also accounts from both parents and children of thinking and behaviour having changed in their children in response to GYM, including improved academic performance

and children having 'turned their lives around'. Other parents had observed how their children had become better at managing and controlling their emotions because of contact with GYM and its therapeutic support:

> *"Yeah, definitely his behaviour and his attitude in life. He's just got so much love now…He's always had a big heart, but he just sees things so differently. Instead of like going away and not talking, and maybe sitting in a room, or lashing out or anything, he'll actually come down and talk. Or if he feels he can't talk to me, then it'll be, 'Oh, can I ring* [the GYM mentor]*?"* (Parent #8).

For a child, their ability to act on the advice of mentors, while something of a surprise, could be positive.

> *"Yeah. Because, normally, I'd just – say if someone wanted a fight, I'd normally just give them a fight. But then I remembered* [the GYM mentor] *always said to me, 'In situations, you've just got to walk away' and, thingy, 'Tell someone about it', so that's what I did. It felt better…than normal"* (Child #3).

Another child interviewee reported how her mental health had improved, and GYM had assisted with an onward referral for a bereavement. Children were reportedly able to form strong therapeutic bonds and alliances with GYM mentors. Although parents tended to acknowledge behavioural improvements that had been seen in their children, not all were clear about the extent to which these were attributable to GYM but were sure that having the option of a confidential outlet had helped. One child interviewee highlighted her anxiety at having to potentially retell her personal history to other services in the event of an onward referral following completion of GYM.

> *"I think I was more anxious, like, if I didn't have* [the GYM mentor]*. I'll have to tell the story all over again, and I don't really want to do that…but* [the GYM mentor] *already knows the background of everything, so that helps a bit more"* (Child #1).

Support from GYM had also provided some parents with the impetus to seek help they needed while also improving the relationship with their children.

> *"It's made me start my counselling now…I have counselling sessions with my doctor on a weekly basis, so I think while he's getting support, I'll get myself support too. So it's kind of everything is kind of coming together all at once, and I feel now I'm actually moving forward in my life. And I think* [my son] *– mine and* [his] *relationship has got a lot better as well, through having the support from GYM"* (Parent #1).

Like the stakeholders, parents noted that a particular strength of the GYM model was to persist in its efforts to engage children and build a relationship with them. Conversely, past experience with statutory services showed a tendency for them to withdraw support after some instances of non-engagement.

> *"You can't just go into a child that's been in that life and change them overnight. It takes a long time. It can take up to a year to change a child's life, and so the intervention needs to be there longer, and they need to persist with it. Not just say, 'Oh, well, they didn't do the first two sessions, so we're pulling it'"* (Parent #4).

Concern was expressed by some parents about the scope for a relapse to previous behaviours once GYM support ended. One parent had felt the loss when her therapeutic support came to an end and was anxious about the prospect of the same happening to her son. While interviewees were generally apprehensive

about the prospect of losing the support offered by GYM at some point, some felt they had learned a great deal from the weekly contact and the online content published by the project. It was clear from the interviews conducted with parents that their association with GYM had improved their confidence, capacity, and ability to better respond to a range of situations they might face with their children's behaviour. Despite these behavioural improvements, there was still occasional resistance apparent from significant others.

> *"It's definitely pulled the family together, but, unfortunately, not his dad because his dad's not willing to meet up with* [the GYM mentor] *and my support worker, that have asked him a number of times. He's blocked my phone number, so I can't even have a conversation with him about my son. So it's a case of I feel I have…I have to stand on my own two feet and do this myself"* (Parent #1).

Lessons learnt

Stakeholders

Information about the needs of children at the referral stage can often be partial, with important gaps only filled following conversations with the child and/or family members.

> *"We're developing as we go along. There might be things that we'd like to change about the initial referrals, you know, that we get the right information up front... But that isn't always possible because they don't always know sometimes. We don't find out until the kids tell us"* (Stakeholder #4).

Similarly, sometimes the issues and challenges schools may be facing cannot be fully understood until the project has been able to talk with children. There was also recognition that some of the issues being identified may carry reputational risks for the schools concerned. It requires courage and leadership for them to be acknowledged and tackled.

> *"I know schools don't like to have labels. So they don't like to have services that deal with gangs or their schools to be known as having gang issues. So with GYM, it's actually safe because we ain't got no labels that we're putting on the school…So literally, it keeps the school's reputation safe…So we actually protect that so we could work better with the teachers, the head teacher and the kids"* (Stakeholder #3).

It was acknowledged during the stakeholder interviews that some children will regress or relapse, having made initial progress. This was recognised and accepted as part of the process of change. A more intractable or refractory group of children may require sustained or enhanced motivational work from mentors and therapists. A challenge for the project then was to develop appropriate and effective ways of motivating this small minority who appeared unable to build on the nascent progress they had made with GYM.

Inevitably, perhaps, it was recognised by interviewees that more children could be supported by GYM with additional resources and a commensurate increase in its capacity to work with more vulnerable children. Relatedly, there was recognition from referrers and users of GYM's services of the pressing need for a more sustainable funding model to ensure continuity of delivery for these sorts of programmes that have historically relied on short-term grants.

> *"They need to do more around making their business model more sustainable without grants…try and make it sustainable and then see how we can improve it with grant income. They do an awful*

lot. And, obviously, I know they're supported by the Youth Endowment Fund, but they do an awful lot for free. So even when they go to schools, when they do assemblies, anything like that, it's kind of almost always free…It is a sellable product…I think their organisation is key, and I would hate for them to not be successful with the Youth Endowment Fund again and then not be here…and I don't want it to get to a stage where the funding runs out, and then it's done, because I've seen that on so many occasions with different organisations" (Stakeholder #2).

Service users

GYM's impact, particularly via mentors, had helped families (re)gain trust and had restored one parent's faith in such services. So important and impactful was the support received that one single mother viewed GYM as a second parent, while another viewed their work as *"fantastic"* and considered them to be *"part of the family"*.

"Do you know what? If more kids had support workers like him, I think we'd be in a better place. He really has turned my life – he has made me see positive in services, where I thought there was no hope. He really has turned that around" (Parent #3).

"They're probably more like a family friend, like are part of the family, instead of…They're not – it doesn't feel like it's a job, like, they're doing it through work, they're doing it because they actually care. Like, even outside of their work hours, they're still there to care" (Parent #8).

Some interviewees underlined the importance of good joint working between GYM and other services, which had helped bring about real improvements in their lives. The importance of this partnership working was evident, given the extent of engagement with services for some GYM clients. These experiences also highlight challenges associated with coordinating contact between multiple agencies and risks of overloading service users with concomitant difficulties engaging children with active lives beyond the home.

Monitoring progress using YEF's core measures was accepted by one interviewee as increasingly being a necessary and relevant part of the process associated with engaging with support services. *"I wouldn't care how much paperwork I've had to fill out because I'm grateful of the help that I'm receiving"* (Parent #1).

There was also some recognition of the potential benefits of discussing with project staff and their children some of the issues which emerged. Therefore, monitoring progress and outcomes in this way was not generally experienced as onerous or intrusive.

"It was like an hour, and sometimes half, it depends, like, what I wanted to talk about and how I talked about it, really… I think we done every two, three weeks. Yeah, it was fine" (Child #1).

"We did do some chats, didn't we, of changing things at home and stuff like that…I think it did help a little bit…because it's helped me see how [my son] *is seeing things"* (Parent #6).

Some parents and children were unable to identify any obvious areas for improvement for GYM when prompted for suggestions during an interview. Others, despite struggling to identify areas for improvement, suggested that perhaps an extension of outreach support – including an expansion of the areas covered by the GYM bus, more of a family focus for GYM's intervention, and the presence of a dedicated GYM office or building – could generate additional benefits.

"I think, because instead of being at school, like, I don't mind it, but I think it would be better if they had their own hub, like a local spot, and people go there, and it's got loads of different activities they can do" (Child #3).

"There may be many other things like that they already do that I just don't know about. But I think any expansion of the community outreach stuff they do would be amazing because I know they're kind of limited to how often they can run them…and they're hugely beneficial. Yeah, and I suppose not that we necessarily needed it, but I suppose, as a family, we would have benefited from having some more family intervention" (Parent #7).

As with the referrer, there was some recognition that *"essential"* projects like GYM need a more financially stable footing to continue their work with vulnerable children and families.

"I was wondering how else can they raise the money to continue with their service? Because, to me, it's absolutely vital; it's literally vital…I've watched over the years and the angles that these services come in at…they're not working…Whereas they want to engage with Guiding Young Minds because it's exciting" (Parent #4).

The impact of COVID-19

The first COVID-19 lockdown at the end of March 2020 inevitably had a major effect on the GYM service, as staff followed the government's 'stay at home' directive. All existing clients were contacted following the lockdown announcement, and GYM maintained daily virtual contact from that point on, offering a range of discussion groups, podcasts, games, and competitions in order to continue to provide a service. This amended model was operational within 10 days of the government's announcement. While reportedly a popular adaptation to the GYM delivery model considering the disruption caused by the national lockdown, it was acknowledged by staff that this was not as effective as face-to-face forms of intervention.

The GYM team was considered by service users to have responded in a flexible and constructive way to the restrictions imposed by COVID-19 and social distancing measures. However, they, too, acknowledged that phone-based forms of support were not ideal. GYM was considered to have offered a good peripatetic response. They facilitated engagement via the mobile service, which travelled to the heart of local communities, and made increasing use of social media to reach their target audience.

"This is why I kind of liked what Guiding Young Minds were doing; they go around with a mobile sort of caravan type thing…the bus. And then so they're getting out and about on the street offering them maybe football kickabouts, but distanced, little bits and bobs like that. They're using social media more, and they're utilising social media to get across messages" (Parent #4).

Stakeholders recognised that their services continued to be in demand as they were invited to work with and support children and families during this difficult period.

"I see it as an opportunity to elevate ourselves and to do things that we've wanted to do but haven't had the courage to…in a time of uncertainty. I think COVID has magnified the service because it hasn't stopped us reaching the kids at all" (Stakeholder #3).

The same interviewee clarified that COVID-19 had seen increased demand for GYM services:

> *"We immediately get overwhelmed by referrals, and I think it's because of COVID. Teachers are panicking about the level of need they're seeing. They see symptoms in kids they've never seen before"* (Stakeholder #3).

Of course, there were considerable impacts on service delivery because of COVID-19 and social distancing measures that significantly reduced both the levels and quality of engagement with children and their families. These were particularly pronounced during March 2020.

> *"Well, initially, the lockdown and closing the schools was huge…And these kids do not engage by phone or video. They just don't. We kept making phone calls with them to encourage them and just check, 'Are you OK?', but you couldn't get any movement with them. That just wasn't working so those initial three months were dreadful"* (Stakeholder #4).

This impact was noted, too, by a parent interviewee who had described how her son had been referred to GYM by a school police community liaison officer following a violent incident at school, culminating in her son's exclusion. The parent was keen to engage, but there were reportedly some COVID-19-induced delays after the referral. The catalysing incident had been resolved by the time of first contact with GYM, but the support was still welcomed.

There were some frustrations expressed by stakeholders during the interview process around trying to convince local authorities about levels of risk in cases where children were subsequently re-referred for support but then fell outside the age range of 10–14 years for YEF funding. This was considered reflective of the challenges of effective communication and joint working with a complex client group during the period of COVID-19.

The consequences of disruptions to their transition from primary to secondary school because of COVID-19 were recognised as being potentially far-reaching and enduring, particularly for children regarded as vulnerable. This virtual form of delivery continued until the summer of 2020 when services like those offered by GYM were designated as essential and face-to-face intervention could begin again, subject to a range of protective measures being in place (e.g. sessions were delivered outdoors in settings like gardens or parks, but not in homes). From June 2020, GYM was able to resume a service to schools since many of its clients were considered vulnerable and still attending in person.

As designated key workers, the GYM counselling team, for example, had been able to maintain face-to-face contact throughout the latter stages of lockdown, but this required a degree of flexibility around the way assessments and interventions were delivered in a COVID-19 secure way. The service continued in this format throughout the summer and autumn of 2020, and the virtual service was gradually scaled back during this period but maintained in light of ongoing uncertainty surrounding the pandemic. Unlike pre-lockdown provision, most contact, while social distancing measures were in place, was coordinated by schools, which limited opportunities for accessing children. This was exacerbated by children having to self-isolate due to positive COVID-19 test results, their own or within their class or support bubbles.

GYM endeavoured to establish a routine with children, but the disruption and uncertainty caused by COVID-19, and schools' understandable response to this, complicated matters. There were similar disruptions experienced by referrers, due in part to COVID-19-related sickness and isolation, but some support continued. It was noted by some stakeholder interviewees that given the social isolation brought about by

COVID-19, parents and carers were often grateful and willing to accept the offer of support from GYM. Unless there were reasons that prevented it (e.g. a clinical vulnerability), most children continued to access support from partner agencies during periods of lockdown, with GYM providing flexible intervention to support these organisations.

> *"So, yeah, it was just trying to find a way of making it and doing it safely. Our interaction with GYM, at that stage, when it was kind of like full pandemic, is that they were always on the end of the phone if we needed them. And even if there was a meeting, they still would have come along to try and support where they can"* (Stakeholder #2).

Interviewees described the degree of planning and consultation required with schools in advance of delivering an assembly to ensure it was tailored to the needs and issues faced by the school. However, it had not been possible to deliver school assemblies and larger presentations on the scale originally envisaged because of COVID-19 restrictions during 2020 and 2021. Project staff tried to be creative in how they could engage and interact with service users during lockdown. This included offering children the option of outdoor activities such as walks and cycling (with GYM providing bikes).

As social distancing measures began to be eased after the first lockdown from May 2020 onwards, the project felt more confident in its ability to respond during subsequent lockdowns. Other significant impacts arising from COVID-19 included a reduction in recruitment of young people and new referrals to the service. Referrals from sources like the police continued but in much lower numbers. Other sources, like the youth offending service, stopped making referrals altogether, while school referrals took until early 2021 to recover. The collection of core measures data (for evaluation purposes) was also complicated during periods of lockdown, as it became difficult to carry out full assessments and reviews when working in outside locations. Data collection was back on track by spring 2021.

One unintended benefit that had been realised because of COVID-19 was that the GYM project had a sharper focus on generating more innovative social media and online content than had been envisaged in its original proposal to YEF.

> *"We put out a film yesterday…and in six hours, it had 900 kids watching it…It's made us do things that before we might have been scared to do"* (Stakeholder #3).

Another unintended benefit was realised in the uptake of families that found themselves with no other alternative during lockdown:

> *"… I think at that point in time we were in a really desperate situation as a family, feeling like everything was spiralling with my son. …There's very little out there kind of in our area, so I was really grateful that GYM was around, and there was someone. And I quite liked the appeal of the one-to-one support as well"* (Parent #7).

One of the child interviewees recalled how she had struggled during lockdown, but motivational support from GYM had helped her engage with her studies during this difficult period.

> *"Because you don't really have motivation, like, you don't…So…you literally just get up and go downstairs and do schoolwork. You just don't want to do it because you feel like you're in your own*

home, and you don't want to do work…Yeah. I think [the GYM mentor] *was, like, 'Come on', like, 'You want to go further in life'"* (Child #1).

When fieldwork was conducted for the before-after pilot, interviewees were able to reflect on the impact of COVID-19 over the majority of the YEF-funded delivery period. Their comments are presented here for ease of reading. More detail on the pilot methodology is provided in the second half of this report. Pandemic restrictions initially impacted the process of delivery and capturing data, although these became less pronounced over time:

> *"We got to a school, and they said, sorry, we just had to send the whole class home. The kids we were coming to see weren't – they hadn't tested positive, but somebody else in the class had, and they sent them all home; that was happening frequently. Now, a lot of those kids, I think, are immune now because we're not getting that so much, but* [then we] *were getting teachers at home all the time"* (Staff member #1).

Practitioners and parents/carers also recognised the potentially limiting effect of COVID-19 on progress for young people:

> *"Some of our clients would engage virtually. Some clients we did lose contact with short term because as, for instance, a lot of teenage boys, when they weren't at school, they were just sat at home [...] wanting to play on their computer games, weren't they? And they didn't want to pick up the phone and have a conversation with us or go out. So* [some] *contact did ease off during that time, which was difficult"* (Practitioner #2).

And there was acknowledgement that pressures on schools during the pandemic had affected their buy-in to the intervention:

> *"We've got maybe 10 per cent of the schools who are negative all the way through and always have been, and we're still battling with them [...] They're really negative about anybody coming in to do anything. They feel they've got enough difficulties because of COVID, and they're trying to manage things [...] Whereas the kids will say, we don't want to be seen at home because there's too many people listening. [...] So about 10 per cent of the schools have been hard all the way through, and we've had to find quite creative ways, or going to the park, or all sorts of things because the schools haven't been helpful"* (Staff member #1).

Logic model development

Despite the challenges of COVID-19, the feasibility review indicated that the GYM intervention was largely working as intended. Some of the balance of inputs to the model had varied at different points. For example, more social media and less face-to-face activity during the first lockdown, but the type of inputs foreseen, outputs generated, and outcomes or impacts predicted have not been revised. As such, the logic model and theory of change were carried forward to the pilot phase.

Conclusion

Table 5. Summary of feasibility study findings

Research question	Finding
What factors support or interfere with the project's successful delivery?	A consistently identified strength of the project was the use of mentors with lived experience who were considered credible and relatable. Interviewees described good working relationships with GYM and expressed a considerable amount of respect, admiration and appreciation for the work delivered by the project. COVID-19 and social distancing measures significantly impacted service delivery and reduced both the levels and quality of engagement with children and their families. This hampered delivery of school assemblies and larger presentations. The collection of core measures data was also complicated during periods of lockdown. The GYM team responded flexibly and constructively to these restrictions – e.g. implementing a virtual service and increasing the use of assertive outreach, peripatetic and other mobile forms of delivery, its use of social media, and their services continued to be in demand.
Has the project demonstrated feasibility in recruitment, retention, and reach?	The project demonstrated its recruitment, retention, and reach were feasible. As part of outreach, GYM delivered 23 workshops to 3,537 pupils in 19 schools during the feasibility phase. For targeted support, 98 children had been referred to GYM, of whom 71 went on to engage with the project. Almost three in five of the referrals (56) were received from 21 different schools selected by ASSIST as part of their universal outreach. Eighty-nine per cent of those engaging with GYM were still in contact with the project by the end of the feasibility phase or had completed and been discharged.
What are service users' experiences and views of the intervention?	Interviewees were overwhelmingly positive about GYM. There were powerful testimonies from parents describing the amazing, fantastic, and life-changing support offered by GYM, in particular, via its mentors. Some parents expressed concern and anxiety about the scope for a relapse to past behaviours once GYM support came to an end. Few were able to suggest or identify areas for improvement. Suggestions that were offered focused on: an extension of outreach support – including an expansion of the areas covered by the GYM bus, more of a family focus for GYM's intervention, and the presence of a dedicated GYM office, building, or hubs.

Evaluator judgement of intervention feasibility

The GYM project demonstrated that its recruitment, retention, and reach were feasible. During the feasibility phase, 98 children had been referred to GYM, of whom 71 went on to engage with the project. By July 2021, almost three in five referrals (56) were received from 21 different schools, of a potential 44. Eighty-nine per cent of those engaging with GYM were still in contact with the project by the end of the feasibility phase or had completed and been discharged. GYM also delivered 23 workshops to 3,537 pupils in 19 schools.

Children were referred to the project via a range of sources during the feasibility phase, including primary and secondary schools, the police, the youth offending service, social services, and other partners. The

project would continue to work with these organisations and anticipated continued referrals from them for the remainder of YEF's launch round funding period (eventually extended to the end of April 2022).

COVID-19 and social distancing measures significantly impacted service delivery and reduced both the levels and quality of engagement with children and their families. The GYM team responded flexibly, creatively, and constructively to these restrictions, and their services continued to be in demand.

A consistently identified strength of the project was the use of mentors with lived experience who were considered credible and relatable. Stakeholder interviewees described good working relationships with GYM and reported a considerable amount of respect, admiration, and appreciation for the work delivered by the project.

Overall, the experience of the project had been an overwhelmingly positive one for family interviewees (three young people and eight adults with parental responsibility). There were accounts from both parents and children of thinking and behaviour having changed because of GYM support, including improved relationships within the family, better academic performance, and children generally having 'turned their lives around'. Some parents had observed that because of contact with GYM and its therapeutic support, their children had become better at managing and controlling their emotions and responded more appropriately to negative or dangerous encounters.

Stakeholders and families recognised the need for a more sustainable funding model to ensure continuity of delivery for these sorts of programmes, which historically have led a hand-to-mouth existence on short-term grants. It was difficult for service-user interviewees to identify or propose other areas for improvement. Where suggestions were put forward, these tended to focus on the scope for additional benefits to be generated via:

- an extension of outreach support – including an expansion of the areas covered by the GYM bus;
- more of a family focus for GYM's intervention; and
- the presence of a dedicated GYM office or building where its services could be accessed.

Interpretation

Referrals were slower than originally anticipated at the start of the project as the GYM service was established, promoted, and responded to COVID-19. Over time, success in generating referrals meant that at different points during the feasibility phase, it became necessary for GYM to introduce a waiting list.

Those young people targeted by GYM were regarded as being largely neglected or overlooked by local services. Families could often be found in a state of crisis and in urgent need of support for their children at the point of engagement with GYM. Trauma, crime, and violence were reportedly consistent features of many GYM service users' lives. The project worked with a few girls who were considered to have had a very specific profile and important vulnerabilities linked to child sexual exploitation and gangs. A number of children were identified as being at risk because at least one parent (typically the father) was gang-involved. This risk factor generated increased demand for GYM's services from the police. A small proportion of parents the project would need to involve were criminally active and/or otherwise less willing to engage with GYM services. The absence of what might be considered a stable, pro-social male role model in many

children's lives was common, while some home environments and family relationships could be experienced as detrimental to the child's well-being (and potentially that of others in the family).

There was an emphasis throughout the project on building capacity and resilience within the family so that they were better placed to meet challenges going forward. Success was measured in terms of improved relationships between children and parents, individual behaviour change and the potential for that change to positively impact others.

An intractable or refractory group of children may require sustained or enhanced motivational work from mentors and therapists. A challenge for the project going forward was to develop appropriate and effective ways of motivating this small minority who appeared unable to build on initial progress they had made with GYM. A challenge for the evaluation, and in particular if this were to move to a trial, would be that this group requires even more flexibility in the duration of the intervention.

Implications for pilot study

Notwithstanding delays and complications arising from the social distancing measures imposed by government in response to the COVID-19 pandemic, the GYM project had successfully implemented YEF's core measures in its routine interaction with service users during the feasibility phase. A key focus for the reporting of the subsequent pilot phase is to assess the extent to which the GYM project has achieved its intended outcomes using YEF's core measures and assessing change over time.

An audit of the core measures collected by the project conducted in March 2021 showed that data relating to 51 children screened by the project and 33 who had been enrolled by GYM had been uploaded to REDCap at this point. This included follow-up data collected using YEF's core measures at three (data recorded for nine out of 31 possible children), six (21 out of 29 possible children), nine (three out of 23 possible children) and 12 months (14 out of 19 possible children). Somewhat inconsistent data completion rates may have reflected teething challenges in uploading to REDCap and the implementation of measures being hampered by delivery challenges associated with COVID-19. The evaluation team's monitoring of REDCap in the transition from feasibility to pilot showed continued use and uploading of these measures by GYM, including the use of the case notes function to document details of client progress, triangulating data from various sources.

Pilot (pre/post-test) study

Study overview

Research questions

The pilot phase evaluated six broad aims designed to assess whether there were predicted improvements in children and young people's behaviour and well-being. This can be best thought of as a short-term assessment, exploring potential changes within young people and their families before, during, and shortly after completion of the intervention. In setting levels for retention and completion, a pragmatic approach was taken, in broad accord with best principles such as those articulated by Eldridge et al. (2016) or Thabane et al. (2010).

As with feasibility, the pilot evaluation was also designed to assess the process of implementation from professional and referrers' perspectives. The aims and associated research questions are shown in Table 6. Please see link to the pilot protocol here.

Table 6. Aims and research questions

Aim 1: To evaluate improvement in core outcomes over time comparing baseline to 1, 3, 6, 12, & 18 months	
Research Question	**Measures**
Describe the client sample at baseline.	Participant demographic information fields requested
Describe the magnitude and direction of change in behaviour.	SDQ (Parents, Young People and Teachers)
Describe the magnitude and direction of change in family functioning.	SCORE 15
Describe changes in trauma.	IES, CRIES-8
Describe changes in engagement in crime.	ESYTC
Where possible, describe and evaluate the effect of baseline status on change over time.	All measures listed for this aim
Describe progress towards achieving goals at six months for clients engaged in the programme.	Bespoke fields and notes in database
Aim 2: Evaluate effect size	
Research Question	**Measures**
Estimate the likely effect size of ASSIST GYM on behaviour.	SDQ
Estimate the likely effect size of the ASSIST GYM intervention on family functioning.	SCORE 15
Aim 3: Describe the referral and screening process	
Research Question	**Measures**
Describe the flow of young people from referral, through evaluation, to engagement on the programme, including reasons for not progressing on the programme.	Referral fields in database, plus additional notes

Evaluate potential bias in selection by considering sample characteristics at different points in the referral process and, where possible, comparison across subgroups, e.g. referral sources.	Referral fields in database, plus additional notes
Aim 4: Client retention and data completion	
Research Question	**Measures**
Do more than 66% of clients complete the intervention?	End of intervention form, end of study form, and additional notes
For clients who complete the intervention, are more than 80% of the outcome measures completed?	End of intervention form, end of study form, SDQ, SCORE 15, IES, CRIES-8, ESYTC
Aim 5: To evaluate the potential to deliver a larger scale randomised trial. Assessment to be made of the following success criteria:	
Research Question	
Referral: If bias in the referral process is identified, can this bias be addressed?	
Retention: At least 75% of young people should be retained in the intervention or evidence that retention can be addressed would be needed.	
Completion: At least 80% of outcome measures at baseline, three, six, nine, 12, 15 and 18 months, or evidence that completion can be improved in a larger-scale trial.	
Given the likely required sample size for a larger-scale trial: a. What population size is required to achieve that sample size? b. Can likely delivery centres with a sufficient population be identified?	
Aim 6: To assess implementation process	
Research Question	**Measures**
Has the intervention been implemented with fidelity?	Interviews
Have service users felt engaged?	Interviews
How responsive has the intervention been to service users, staff, and volunteers (where appropriate)?	Interviews

To assess whether challenges to retention can be addressed (Aim 5), an example challenge might relate to literacy (in English) of the clients or cultural differences in how they experienced the intervention and its underlying assumptions. Additional information on data sources is provided in the section below.

Success criteria and/or targets

The success criteria included reduction in symptoms of trauma, improved emotional regulation, better family functioning, and improved engagement at school. The project's mid- to long-term success criteria related mainly to educational attainment and cessation of involvement within gang and/or anti-social or offending behaviours. It should be noted, however, that the inclusion criteria were deliberately wide and not all outcome measures may be expected to improve for all young people engaged in the programme. For example, there might not be room for improvement on the ESYTC for young people who have never actually offended, albeit deemed at risk of offending.

From an evaluation perspective, the main success criteria for the pilot will be the potential to scale up the intervention to meet a sufficiently large sample size. The sample size for a trial to evaluate effectiveness of

the intervention was estimated from evaluation of the potential effect size. Key criteria to assess evidence of promise were based on the research questions articulated in Aim 5, within Table 6 above.

Participant selection

As with the feasibility study, quantitative analyses were conducted on the entire dataset uploaded to REDCap. All young people referred to GYM within the recruitment phase were thus captured via analysis of this routine monitoring data. To assess the implementation processes, the evaluation team anticipated inviting up to five children and their parents, carers, or legal guardians to participate in an interview to inform the pilot evaluation, subject to the agreed procedure of the therapists on the project discussing this with the parents and young people, as to whether they were willing to be approached or not by the evaluation team. Professional stakeholders (up to five initially envisaged), including managers and delivery staff, were also sampled purposively. It was therefore proposed to conduct interviews, individually, jointly, or within a group, as appropriate, with up to 15 participants associated with GYM. Having initially recruited 15 participants but including only two young people, evaluators were subsequently able to increase the number of children interviewed to five. As such, the implementation process interviews over-recruited to ensure that more children's voices were considered.

Data collection

The ASSIST GYM evaluation draws upon different data sources and methods. These include the use of routine monitoring data collected by the projects, core measures specified by YEF relating to project participants, and qualitative data from interviews and focus groups with project participants and professional stakeholders.

Data collection methods

As with the feasibility phase, the majority of quantitative data collected comprises either data routinely collected within the ASSIST GYM programme or the specified YEF core dataset. Again, it was uploaded to the REDCap system by members of the GYM team and stored securely on university servers. Here too, data collection, data entry, and queries raised by a member of the grantee team were conducted in line with the data management processes as agreed between the grantees and the evaluation team. Follow-ups with the clients were indicated at three (t1), six (t2), nine (t3), 12 (t4), 15 (t5) and 18 (t6) months (feasibility data carried through to pilot, where possible). Routine monitoring, evaluation, and core measures were the same as in the feasibility phase. Table 7 provides a summary of the data collection schedule.

Table 7. Schedule of planned data collection and assessments

	Referral	Screening	Baseline (t0)	3-month follow-up (t1)	6-month follow-up (t2)	9-month follow-up (t3)	12, 15- and 18-month follow-up (t4, t5 & t6)
Demographics	X						
Programme-specific process	X	X					
SDQ			X	X	X	X	X
SCORE 15*			X	X	X	X	X
IES-R*			X	X	X	X	X
CRIES 8			X	X	X	X	X
ESYTC			X	X	X	X	X
Goal setting and attainment			x			x	
End of intervention or engagement form			To have been completed if a client withdraws or when they complete the intervention.				

* These measures were deprioritised by the project due to lack of direct relevance to the GYM client group.

Please note that where families had been enrolled for long enough, then it was intended to compare 12-, 15- and 18-month data against baseline to assess distance travelled.

Data sources

To simplify the description of the data, we use 'clients' to encompass the young people and/or families being considered for intervention, as appropriate. Data were captured separately for young people and their parents or carers. Please note that each client sub-set was recorded in both aggregated and disaggregated ways to allow the evaluation to capture the different referral routes and their different potential experiences of the grantees' interventions. For each of the aims articulated in Table 6, the report now presents the data source:

Aim 1: To evaluate the direction and magnitude of change in core outcomes over time and for ASSIST GYM to assess progress towards achieving goals

The key data source was the data collected on the REDCap database. The source data for goal setting and attainment have been extracted from the client notes provided by ASSIST. Transcription and transfer of anonymised goal-related data for clients from ASSIST to the evaluation team was an ongoing process on a data format separately specified.

Aim 2: To evaluate effect size

Each effect size was estimated from the core dataset specified in Aim 1.

Aim 3: To describe the referral and screening process for the ASSIST GYM programme

Data relating to screening and referral have been identified, and where possible, this was incorporated into the REDCap database. Where the relevant data could not be captured in this way, the source data were the

records held by the grantee. Again, the transfer of anonymised data was an ongoing process in a data format separately specified.

Aim 4: Client retention and data completion

Attendance at therapeutic (including wraparound-type) sessions and the client completion record were intended to allow evaluation of engagement in the ASSIST GYM intervention, and the database record provides information on data completion.

Aim 5: To evaluate the readiness to deliver a larger-scale randomised trial

Evaluation of this aim used all the data collected in a summary process after all other aims were evaluated.

Aim 6: To assess implementation process

The key focus of the pilot qualitative work was to better understand matters that support or interfere with the intervention's delivery; the ongoing implementation processes of the intervention's recruitment, retention and reach, alongside service users' experiences and views of the intervention. The interviews helped evaluators to further assess acceptability of and engagement with ASSIST GYM by the young people and the views of their parents or primary caregivers. Interviews with practitioners and referrers also helped to assess whether and potentially how successfully processes can be managed and upscaled.

All interviews were conducted by the evaluation team and recorded, usually via video conferencing tools. In some instances, to conform with participant preference, these were sound files only.

Table 8. Intended methods overview

Research methods	Data collection methods	Participants/data sources (type, number)	Data analysis methods	Research questions addressed
Quantitative outcome assessments	Routine monitoring data collected by GYM (including core measures)	Those referred, screened, accepted, discharged, AND completing GYM services. Includes progress against outcomes, as measured using YEF's core measures	Descriptive and where meaningful, inferential statistics	Aims 1–5
Implementation process	Qualitative interviews	Purposive sampling of professional stakeholders (N=5) and opportunistic sampling of parents/carers (N=5) and children (N=5) accessing GYM services	Thematic analysis	Aims 1–6, primarily 6

Analysis

This section outlines the analytical strategy adopted within the pilot evaluation. Aims will be considered in turn, explaining how they were assessed. The findings of those assessments will then be presented in subsequent sections of this report.

Aims 1 and 2: To assess the direction and magnitude of change in the main outcomes for the families in the programme. To assess the potential effect size of the intervention

The analysis considers each of the four YEF core measures independently, as well as the progress against the goals set within the ASSIST GYM programme for each client. The initial analysis is considered through descriptive statistics for the sample as a whole at all time points, including all demographic and other factors. The analysis describes change over time as a mean change from baseline and estimated effect size (with confidence intervals) at three (t1), six (t2), nine (t3) and, where possible, 12 (t4), 15 (t5) and 18 (t6) months.

For the SDQ, analyses were run across all domains, including the pro-social scale and the internalising and externalising scales. The pattern of change across all domains and totals was the same. To avoid repetition in reporting, the totals are reported alongside impact, without specific domains.

It was intended that sensitivity analysis would consider the influence of baseline characteristics and missing data. As the dataset is small, any models would have to constrain the number of variables included. The analysis would seek to demonstrate gross effects of baseline variability and missing data (by replacement of missing values) and interpret any influence on the observed change over time. However, the data completion rate was too low to allow for meaningful interpolation of data. Thus, sensitivity analyses will not be reported in the findings section below. A particular method to evaluate the effects of missing data was not specified a priori, as the aim of the evaluation is exploratory (i.e. a pilot study). The methods applied would have been designed to evaluate particular questions as they had arisen rather than to undertake a more structured, model-driven approach.[3]

These 'errors of estimation' cannot be informed by adjusting the type I error rate in any set of statistical comparisons in the current pilot study. The evaluators have therefore chosen to provide the observed data and provide a commentary on issues judged to be important to address in the design of a future study rather than using a method of adjusting for statistical error that compounds the lack of statistical power in any pilot study.

[3] The evaluators are grateful to an unknown reviewer who asked us to comment on whether adjustment for repeated tests was necessary. A focus on, interpretation of, and extrapolation from p values for comparisons in small-scale before-after pilot studies is inherently risky (Kisten and Silverstein 2015). Adjusting for family-wise error rate (or per-family error rate as with Bonferroni) trades type I error against type II error and is not likely to be informative (Frane 2015; Armstrong 2014). A suggestion that all the comparisons fall within a particular family of comparisons within a design of this kind is likely incorrect, making the use of Bonferroni inappropriate and any other type of correction focusing on family-wise error prone to inflation of per-family error. The objective of the pilot studies is broad and should be used to test evidence, in-the-round, whether there is a potential benefit to the intervention that can be evaluated within a trial. Focusing too closely on the statistical outcome of before-after comparisons and, specifically, the p value is likely to provide an inflated confidence in the precision of the outcome where there are many design features of a future study that could not be evaluated with the current datasets.

It was intended that ASSIST GYM goal attainment would have been characterised as the graded progress against goals for each family. Where there was more than one goal for a client, identification of the main goal would have been used. Progress against the goals was intended to have been characterised on the scale in a contingency table and summarised as a median with interquartile range. The intention to assess goals was for individual goals to be measured in a standardised way utilising the Goal Attainment Scaling protocol outlined by Turner Stokes (2017).

Aim 3: Describe the referral and screening process

Analysis of the referral and screening process is descriptive. A flow chart is used to show the flow of clients from referral through screening to completion of the intervention. Focus is placed on why clients are not selected for the intervention at each stage. Descriptive analysis seeks to evaluate through tabulation the extent to which selection of clients is subject to bias, excluding particular groups of clients. Numbers of clients are small, but where possible, analysis uses $\chi 2$ to aid interpretation of the data.

Aim 4: Evaluate client retention and data completion in the programme

For families starting the programme, retention to the end of the programme is important. Retention is defined as completing at least 66% of treatment sessions. Incomplete sessions can be through missing sessions intermittently or regularly across the treatment period or by withdrawing from the programme early.

The number of families failing to attend scheduled appointments is estimated, with the number and proportion of missed appointments and assessment sessions at each time point described. Overall adherence to the intervention (appointments) is estimated as a proportion of appointments missed for each family and the proportion of families attending at least 66% of treatment sessions. Characteristics of families which do and do not complete the programme have been tabulated, and differences are highlighted.

Data completion has been tabulated for each outcome. The choice of limits to define treatment adherence is a difficult challenge for evaluations, but most studies have limits between 66% and 75%. In general, limits can be defined by the intervention team, which makes a judgement about the minimum number of therapeutic sessions that should be attended to achieve a reasonable therapeutic effect. However, this is only informative, where clients are required to attend a high proportion of available sessions to achieve the desired intervention outcome.

In practice, adherence determined in this way tends to have a biphasic distribution; that is, clients tend to attend therapeutic sessions or not, and attendance is either very low or greater than two-thirds. By using a 66% limit, the analysis allows for measurement error inherent in small samples without being too penalising (Midgley et al. 2018). This also means that if non-adherence was a significant issue, it could easily be detected and flagged.

Aim 5: Evaluation of success criteria

Readiness to progress to a larger-scale efficacy or effectiveness is assessed. A sample size is estimated following analysis in Aim 2. The progression criteria consider the potential to deliver a trial of this magnitude.

Progression to a larger scale efficacy or effectiveness trial considers four main criteria.

1. Bias in the referral process and whether any bias can be addressed

Bias is evaluated by highlighting any differences between families that start therapy compared to those that are referred but are not accepted onto the treatment programme. The reasons for not progressing are listed.

2. Retention of clients in the intervention

Retention is an important secondary indicator of bias. Retention is initially evaluated by determining whether ASSIST is successful in retaining at least 75% of families that start GYM. Secondary analysis considers any apparent differences between families that do and do not complete the programme.

3. Sufficiently robust and unbiased data completion

Data completion for each of the outcomes have been tabulated. Data are defined as complete for scales where sufficient data for each outcome has been completed to evaluate a scale score. There is an allowable margin of missing data for each scale that allows for pro rata estimation of the scale score for a client. Where more responses are missing than the margin on any one scale, the data point (scale score for that client) is declared as missing.

4. Whether a trial of sufficient magnitude could be delivered

Analysis proceeds by tabulating the assessed outcomes from analysis of each of the first three aims and any mitigations identified in the qualitative analysis. This will provide a summary statement of the success criteria, any bias in selection, and suggested adjustments for future studies. The potential number of recruiting centres has not been calculated, given the high number of locations engaged via the outreach activities.

Aim 6: Implementation process

Interview data were transcribed sufficiently for thematic analysis. Due to the richness of the dataset, the evaluation incorporated emerging themes more fully within this analysis and moved towards a more inductive analysis than initially outlined in the pilot protocol. Narrative fields from the REDCap database containing information, such as matters perceived to impede or facilitate positive outcomes, were also incorporated into the qualitative analysis. The evaluation of ASSIST was one of four evaluations conducted concurrently by the evaluation team, commissioned by YEF. This meant that emerging themes could be developed for each grantee, and it will be possible to conduct cross-intervention, secondary analyses subsequently.

A reflexive approach was taken whereby transcripts were closely read, and themes and related sub-themes were developed, first transcript by transcript, then tested and refined against the cohort as a whole. Analysis was split into two sets: i) professional stakeholders (incorporating implementation practitioners, managers, and referrers) and ii) families (incorporating those with parental responsibility for the child and children/young people themselves). Themes, initially created, were shared within the evaluation team to test for consistency and to provide a degree of inter-rater development. This resulted in some shifting of sub-themes and reframing of themes. Analysis then continued, in this reflective way, to develop a thematic map and the findings that are presented below.

Timeline

Table 9. Timeline

Date Completed	Activity
24.02.22	Before-after pilot inception, including finalised pilot protocols and fieldwork extension
30.04.22	Completion of all pre- and post-pilot focus groups, stakeholder interviews, and REDCap data download
30.06.22	Data analysis (pilot data) and cleaning and preparation of data for archiving
30.09.22	Submission of draft final reports
31.01.23	Final report drafting, peer review, and revision (feasibility and pre-post pilot)

Findings

Participants

To assess the implementation process, interviews were completed with eighteen participants: five young people, five people with parental responsibility, two referrers, one social worker, two mentors, two therapists, and one manager.

Within the quantitative dataset, 118 potential clients were screened; GYM enrolled 74 (62.71%). Demographic information of those initially screened and enrolled, alongside reasons for non-enrolment, may be seen in Table 11 below.

At baseline, completion rates from children, parents, and teachers of the core measures were high, approximately 92% for children, 84% for parents, and 51% for teachers. By 12 months, there were still 69 young people enrolled. This gives a retention proportion of 93%, although data completion rates had fallen to approximately 30% of the potential cases.

The study plan outlines the objectives of the pilot study and the analysis reported. Table 10 summarises the intended data collection schedule for GYM. In the rest of this section, data are presented in the easiest order for interpretation and in ways that show how the analysis was built. All aims will be covered. Reporting starts with Aim 3, then moves back to Aims 1 and 2. For Aims 1–5, quantitative findings are presented first, and then relevant qualitative themes are considered. Aim 6 is entirely assessed through qualitative analysis.

Table 10: Data collection schedule at each time point

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)	15 months (T5)	18 months (T6)
GYM number	X								
Date of referral	X								
Age	X								
Gender	X								
Ethnicity	X								
Family background	X								
Referrer	X								
Therapist		X							
Risk score (0-16)*		X							
Main difficulties	X	X							
Index of Deprivation									
SDQ			X	X	X	X	X	X	X
Score 15*			X	X	X	X	X	X	X
IES*/CRIES8			X	X	X	X	X	X	X
ESYTC			X	X	X	X	X	X	X
Study End Form							X	X	X

* Deprioritised by the intervention team

Aim 3: The referral and screening process

Starting with Aim 3, the referral and screening process is evaluated first and is summarised in the flow chart in Figure 2 and in Tables 11 and 12. Of the 118 families referred to ASSIST, 44 (37%) were not accepted into the service for support. Thirteen young people did not meet the criteria required, 20 did not want or need support, nine were unable to engage, and two were lost to follow-up. Seventy-four young people were enrolled in the programme. For the majority of the referred young people, the child was 12 years old, predominantly male (90%) and white (66%) or mixed race (21%).

Figure 2: CONSORT 2010 style flowchart of referrals

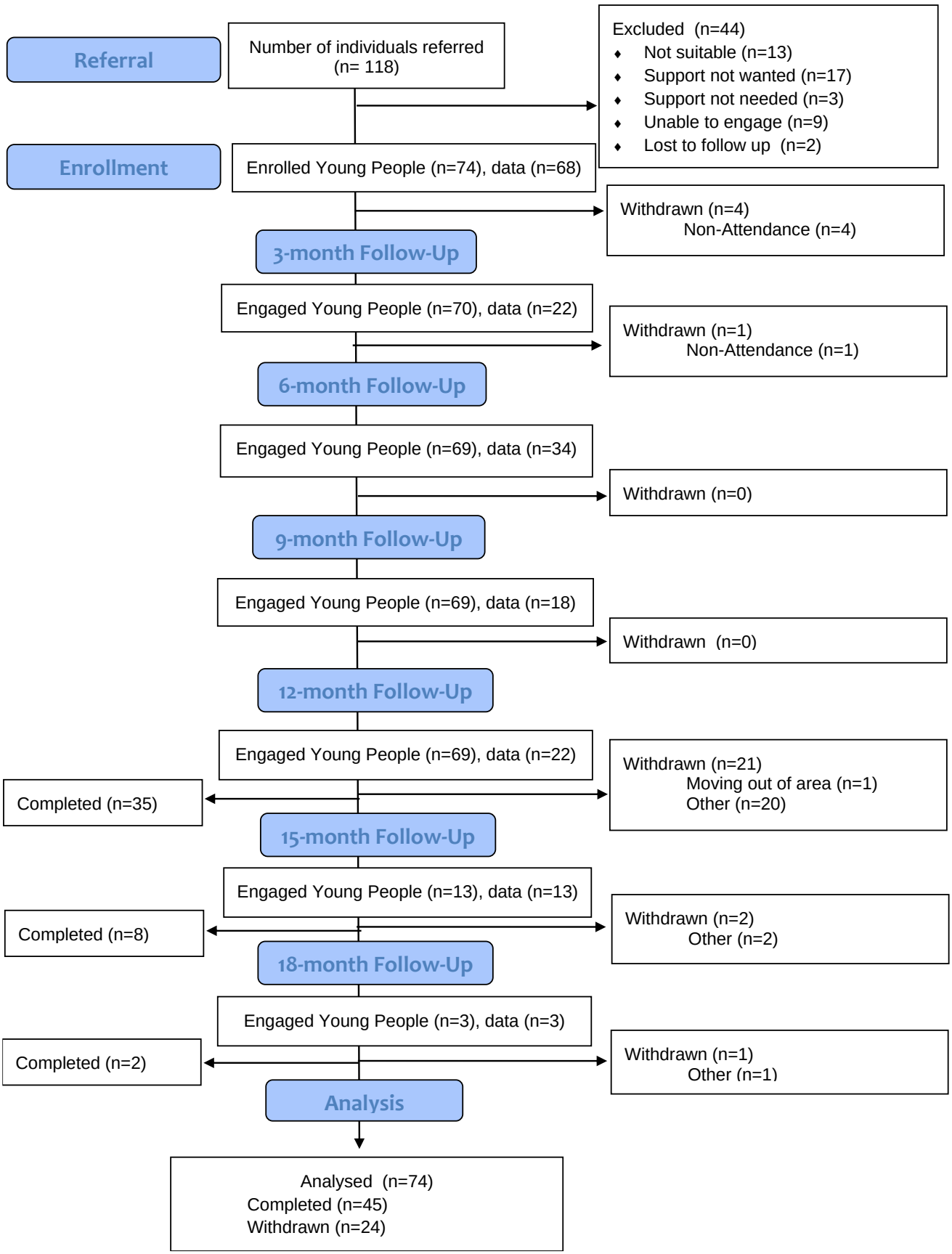

Table 11 shows that there were very few differences between referred young people who were enrolled and those who were not. The only statistically significant finding here was that the majority of females who were referred went on to be enrolled (11 enrolled out of 12 referred [92%]), whereas, for boys, a lower proportion were enrolled (63 enrolled out of 106 referred [59%]). Some other findings that may also be of interest are close but not quite statistically significant. In particular, where referrals were from the parent or from the YOS worker, they were commonly enrolled, whereas referrals from the social worker, police, or the school tended to be less likely to be enrolled. In this context, it should also be noted that there were very few YOS workers and parental referrers, with the majority of referrals and enrolments coming from police and school. For those who withdrew from the intervention (Figure 2), notes in the database indicated that the main reasons for choosing 'other' were: change in circumstances, 'chaotic' family life, and disengaging during COVID-19. In at least one case, it is also noted that there was subsequent re-engagement, although no follow-up was possible within the evaluation.

Table 11. Demographic characteristics of young people referred, unsuitable (referral only), and enrolled

		Overall	Referral only	Enrolled	Test of significance
n		118	44	74	
Child's age mean (sd)		12.40 (1.91)	12.52 (2.39)	12.32 (1.57	t= .54, p=.59
Child's gender n (%)	Male	106 (89.83%)	43 (97.73%)	63 (85.14%)	χ^2= 4.79, p=.03
	Female	12 (10.17%)	1 (2.27%)	11 (14.86%)	
	Prefer not to say	-	-	-	
Ethnicity n (%)	White	78 (66.10%)	30 (68.18%)	48 (64.86%)	χ^2= 10.72, p=.06
	Black	8 (6.78%)	5 (11.36%)	3 (4.05%)	
	Asian	4 (3.39%)	1 (2.27%)	3 (4.05%)	
	Mixed	25 (21.19%)	5 (11.36%)	20 (27.03%)	
	Other	2 (1.69%)	2 (4.55%)	-	
	Not provided	1 (.85%)	1 (2.27%)	-	
Referrer	Parent	7 (5.93%)	-	7 (9.46%)	χ^2= 10.02, p=.08
	Social Worker	5 (4.24%)	3 (6.82%)	2 (2.70%)	
	Police	30 (25.42%)	10 (22.73%)	20 (27.03%)	
	YOS Worker	2 (1.69%)	-	2 (2.70%)	
	School	65 (55.08%)	25 (56.82%)	40 (54.05%)	
	Other	9 (7.63%)	6 (13.64%)	3 (4.05%)	

Time from referral to enrolment ranged from same day to 175 days. However, one client initially did not engage with the grantees but re-engaged a year later, giving a time from referral to enrolment of 440 days. To provide additional insight into referral to enrolment ranges, the mean was 37.14 days (s.d. 62.79), the median was 15 days, the 25th percentile was seven days, and the 75th percentile was 49 days.

It appears that there is very little risk of bias in the referral and screening process, and on most occasions, the referred young people either were not eligible or did not need or want support (28%). Eleven potential clients (8%) did not or could not engage with the programme.

Additional information regarding enrolment was available from the interviews. Practitioners recognised that a proportion of young people were not able to engage in the intervention, particularly therapeutic aspects. Young people can also lack the foresight to understand how the programme could benefit them.

> *"I would say probably 90% of the time, they are ready, and they're in that place. However, there are one or two that will feel that actually they're not ready, or they're not in that place, or actually they don't need, they don't feel that they require support, and then you have to obviously respect that. What I found is quite interesting is that a couple of months later, or somewhere down the line, they do come back [...] But there are obviously young people out there that feel that, actually, they don't need that support, and they're not necessarily at the right place at that time to receive"* (Practitioner #4).

Aim 4: Client retention and data completion

Client retention and data completion is outlined in Table 12. Under the principle of intention-to-treat, data completion is considered here in relation to the proportion of records at each time point in comparison to the number of young people enrolled in the programme (n=74). At each time point, the number of cases remaining in the programme is also highlighted. It is noted that the COVID-19 pandemic was a significant factor in disrupting follow-up during this period.

The number of cases remaining on the ASSIST programme for 12 months is high (69/74, 93%) and falls off at 15 (n=12) and 18 months (n=3). Therefore, the focus is on the data up to 12 months. In general, the children were more likely to provide data than the parents, and the maximum number of families providing data at follow-up is 34 (46%) at six months and 22 (30%) at 12 months. It is also noted that, in common with most programmes, the collection of data relating to goal setting was compromised by the needs of clinical practice and could not be reported here.

Table 12 indicates both a very low rate of data completion and the potential for significant bias. Tables 13 and 14 provide a comparison between the young people and families (n=40) for which at least some data are reported compared to those for which no data have been collected. The baseline characteristics are reported. In general, the two groups are very similar, with the only apparent difference being that the number of reported delinquent activities are *lower* among the children where no data have been collected than for those families where some data have been collected at follow-up. While the data do not indicate a difference between the families that provided data and those that did not, there remains the potential (outlined below) for significant differences in response to the programme between these groups.

It is noted that the ASSIST programme provided no data on the number of sessions attended by the young people but did report how many were retained in the programme at each time point. While data completion was compromised, client retention, defined by the programme, remained high. The programme reported that 69 (of 74, 93%) were retained in the programme for 12 months. Overall, 45 young people are reported as having completed the programme, 24 are reported as (other), and the remaining three were still on programme, meaning that 68% of clients enrolled remained engaged in the programme.

Table 12: Summary of data collected at each time point

	Referral n=118	Screening	Baseline (T0) Enrolled n=74	3 months (T1) Remaining (n=70)	6 months (T2) Remaining (n=69)	9 months (T3) Remaining (n=69)	12 months (T4) Remaining (n=69)	15 months (T5) Remaining (n=13)	18 months (T6) Remaining (n=3)
GYM number	118 (100%)								
Date of referral	118 (100%)								
Age	118(100%)								
Gender	118 (100%)								
Ethnicity	118 (100%)								
Family background	MISSING								
Referrer	118 (100%)								
Therapist		MISSING							
Risk score (0-16)*		MISSING							
Main difficulties		MISSING							
Index of Deprivation		MISSING							
SDQ			P: 62 (83.78%)	P: 21 (30%)	P: 32 (46.38%)	P: 18 (26.09%)	P: 21 (31.82%)	P: 12 (92.31%)	P: 3 (100%)
			T: 38 (51.35%)	T: 18 (25.71%)	T: 14 (20.30%)	T: 13 (18.84%)	T: 15 (22.73%)	T: 9 (69.23%)	T: 3 (100%)
			C: 68 (91.89%)	C: 22(31.43%)	C: 34 (49.28%)	C: 18 (26.09%)	C: 22 (33.33%)	C: 13 (100%)	C: 3 (100%)
Score 15			P: 21 (28.38%)	P: 12 (17.14%)	P: 11 (15.94%)	P: 16 (23.19%)	P: 13 (19.70%)	P: 12 (92.31%)	P: 3 (100%)
			C: 68 (91.89%)	C: 21 (30%)	C: 34 (49.28%)	C: 18 (26.09%)	C: 22 (33.33%)	C: 12 (92.31%)	C: 3 (100%)
IES			0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
CRIES8			5 (6.76%)	22 (31.43%)	34 (49.28%)	16 (23.19%)	21 (31.82%)	12 (92.31%)	2 (66.67%)
ESYTC			43 (58.10%)	18 (31.43%)	20 (28.57%)	18 (26.09%)	22 (33.33%)	12 (92.31%)	3 (100%)
Study End Form			4 (5.41%)	1 (1.43%)			56 (85.85%)	10 (76.92%)	3 (100%)

Notes: P – Parent, T – Teacher, C – Child. Family background, engagement with other programs, therapist, risk score, main difficulties, index of deprivation not on database.

Table 13. Comparison of demographics between young people who did or did not complete study measures

		Completed	Withdrew	Test of significance
n		45	24	
Child's age mean (sd)		12.51 (1.52)	12.08 (1.56)	t= 1.11, .27
Child's gender n (%)	Male	39 (86.67%)	21 (87.50%)	
	Female	6 (13.33%)	3 (12.50%)	χ^2= .009, p=.92
	Prefer not to say			
Race n (%)	White	28 (62.22%)	17 (70.83%)	
	Black	2 (4.44%)	1 (4.17%)	
	Asian	2 (4.44%)	0	χ^2= 1.33, p=.72
	Mixed	13 (28.89%)	6 (25%)	
	Other	-	-	
	Not provided	-	-	
	Parent	5 (11.11%)	1 (4.17%)	
Referrer	Social Worker	1 (2.22%)	1 (4.17%)	
	Police	16 35.56%)	3 (12.50%)	χ^2= 6.16, p=.29
	YOS Worker	1 (2.22%)	1 (4.17%)	
	School	21 (46.67%)	17 (70.83%)	
	Other	1 (2.22%)	1 (4.17%)	

Note: Four clients withdrew between enrolment and the baseline measures, and one withdrew at three months without completing any measures; they are not included in the table above.

Table 14. Comparison of mean scores between families that did or did not complete study measures

		Completed		Withdrawn		Test of significance
		n	Mean (sd)	n	Mean (sd)	
Parent	SDQ	40	20.15 (6.77)	22	18.05 (7.30)	t=1.14, p=.26
	Score-15	7	27.14 (9.34)	14	27.43 (8.61)	t= -.07, p=.95
	SDQ	45	18.4 (6.25)	23	17.57 (6.06)	t= .53, p= .60
	Score-15	45	36.36 (10.47)	23	29.87 (8.08)	t= .2.60, p= .012*
Child	CRIES-8	0	-	5	6 (13.42)	-
	ESYTC	23	5 (.98)	20	5.9 (1.05)	t= -.63, p=.53
Teacher	SDQ	23	18.74 (5.10)	15	20 (6.44)	t= -.67, p= .51

Note: Four young people withdrew between enrolment and the baseline measures, and one withdrew at three months without completing any measures; they are not included in the table above.

Practitioners emphasised the importance of partnership work to support young people's sustained engagement. This starts with opening up dialogue and building relationships with a young person's caregivers and family to gain their endorsement:

> *"*[It's] *been very, very positive, and I would say 99% of the time, we're able to have that good connection and build that network of support with family members as well. So, it's very minimal that we might get a parent or carer, or a family member, that's reluctant to engage… you're building a*

whole working together to build a whole network of support around a child. You're building connections with the schools, the family at home, and you see much bigger results when you have everybody supporting and everybody understanding what's going on for that client, and understanding their needs" (Practitioner #2).

Parents and carers also highlighted psychological barriers young people might have that limit involvement in the programme and/or stall their progress through lack of readiness to engage:

> "[A mentor] *told him that if you stop your behaviour, like going out to do drugs again, if you stop it, I will continue seeing you. Even though when the funding is no more there for me, I will use my personal resource to make sure I will be there for you [...] but, unfortunately, he couldn't stop doing the drugs"* (Parent/carer #2).

It is important to note here that the mentor is going beyond their employment contract. The intention is clearly good. Yet, it is possible that such an offer may be seen as pressuring by the child and/or could even raise safeguarding concerns about ongoing contact. It should be stressed that no such concerns were raised. See the 'Lessons learnt' section below for more information.

For some young people, difficulties establishing trust can be a challenge:

> "[I] *didn't give up on him; I was so explaining to him that I still care for you, and I still want to be there for you, and I want you to have a good life* [and] *have memories about a good childhood life.* [He] *has told some of the professionals that he has tried everything for me to push him away, and he's realised that I'm not pushing him away. So why am I caring for him?* […] *I tried to explain to him that* […] *everyone in this world needs someone in their life, and that's what I'm trying to do for you"* (Parent/carer #2).

Furthermore, some young people are reluctant to establish relationships with professionals, which is necessary to engage in the programme:

> *"It is difficult because some children do have a lack of trust in professionals as well.* [With] *a client recently […], I'm his third therapist, and he's had various other professionals as well involved before we became involved with him. […] Sometimes, there are difficulties, especially depending on the case around the individual as well. If they've had social workers […] and other services involved. And sometimes it can be very difficult to build relationships with children, because [...] it's too much for them. There is a lot of services involved, and they might be seeing a lot of different people, so we try and be aware of that"* (Practitioner #2).

Interviews also provided information about the readiness to engage with the measures required for the evaluation, including emerging issues with the processes for data capture, such as the timing and choice of core measurements and purposes of equipment.

> *I was very sceptical about it, first of all, because when it was first presented to us, it was huge, and it was a couple of weeks before they* [YEF] *told us you don't have to use all of it, which was a huge relief [...] There was a lot of things we didn't understand at the beginning. I think as much wrong on our side as anyone else's, we didn't get it. We thought the tablets were to help us with recording the data. They weren't, they were to actually take out and use on the street or within people's homes, and we*

didn't know that. So by the time we got to the stage where the tablets were ready, we already had an established way of working" (Staff member #1).

There may be a need to review measures deployed, or more particularly, to consider how they are deployed and interpreted:

> *"I think they* [YEF measures] *are all appropriate, but we wouldn't necessarily use them for all clients…There are a couple more that we use as ASSIST that we probably would add in, like anxiety and depression scales that we haven't used* [for] *the YEF [...] The family scale, the SCORE-15, we probably wouldn't use as much because we are working with mostly individuals. We're not doing a lot of family work, so I think we will use that where it's appropriate, but not all the time because we want to cut it back as much as we can. Kids hate filling in forms, and we've had to be really creative in ways of doing it."* (Staff member #1)

The staff member went on to explain that understanding the context of particular clients and the relationships being built with practitioners is important:

> *"Very often kids who are referred by the police because they're doing some quite awful things, the SDQ marks them as perfectly normal and average, and you wouldn't think they were doing anything wrong. But by the time you get to the first review, they know you better, and they're able to be more honest, and then their scores are much, much worse than* [at] *the beginning…The SDQ we found brilliant, and we would definitely carry on using that [...] we'd never use the SDQ before, and we didn't understand how to do it. [...] I think would have helped, would have been an introduction to it, talking through it, understanding it […] The Edinburgh scale, or the part of the Edinburgh scale that we use, is brilliant! It gives us so much information that we can use in sessions to work with the kids. If we weren't asking those questions, we would have no idea they were into some of the things that they're into"* (Staff member #1).

Aims 1 and 2: The direction and magnitude of change in the main outcomes and the potential effect size

The mean scores for each of the outcome measurements are presented in the following tables for each of the time points: SDQ (Tables 15 and 16), Score 15 (Table 17), and CRIES-8 and ESYTC- Sweep 3 (Table 18). The IES-r was not completed at any of the time points. Four (5.41%) families withdrew from the study at the baseline time point via non-attendance or non-engagement.

In general, where data have been reported, the families report a significant improvement for the child. The SDQ total scores at baseline are reported as very high and are reduced to slightly raised by three to six months and are in the normal range by nine months. The impact scores also decline but remain high or slightly raised over time. Similarly, the families report a smaller improvement in the SCORE 15 over time. It is notable that the children report a much higher score at baseline than the parents (34 cf 27) but a very similar level of distress at 12 months and that the parent-reported score increases at six months before falling again. This may indicate that parents did not have a full understanding of the extent of distress in their children at enrolment.

The number of reported acts of delinquency and their frequency (ESYTC) also fall significantly over time. For the CRIES-8, the lack of data at baseline makes comparison difficult, but from three to 12 months, the scores fall considerably. Change in the scores for the outcome measures was evaluated at each time point compared to baseline (see Tables 19–21). For all outcomes, the number of families providing data was well below 75%, making adjustment meaningless. Similarly, no attempt was made to evaluate the effect of missing data (sensitivity analysis), as any attempt to impute missing values would overwhelm the data reported. Further commentary on these issues is reported below.

What is notable is that for most of the outcome measures, the scores fall somewhat by three months and, to a significant extent, by six months, which is maintained through nine and 12 months. For the SDQ, similar patterns are reported for the child, parents, and teacher scores. For the Score-15, very few parents provided data in comparison to the children, and where data are available, the baseline score is much lower. This means that while the children report a significant improvement in Score-15, the parents do not report a consistent gain in this score. However, this is almost certainly attributable to a lack of parent responses at baseline, and as noted above, the parent scores tend to be lower than the children's responses initially, coming closer together over time. We note that the reported effect sizes[4] are large and indicate a robust before-after treatment response (where data are reported).

By six months, a significant improvement in scores is reported with a 7.9 point decrease in the child-reported SDQ Total score ($t=7.4$, $p<0.01$) with a very large effect size $d_z=1.28$, which is maintained to 12 months with a 10-point improvement ($t=6.6$, $p<0.01$) and effect size $d_z=1.44$. Of the other measures, the CRIES-8 presents some difficulty as so few children have completed it at baseline. Nonetheless, there is an apparent significant improvement in the score over time. The Score-15 parent scores show a smaller improvement over time, which is less consistent, but this is probably due to the baseline differences noted above. The mean scores converge over time. For children, the reported Score-15 scores also show an improvement at three months, which is significant by six months ($t=6.5$, $p<0.01$, $d_z=1.2$, and maintained at 12 months ($t=4.8$, $p=001$, $d_z=1.6$). The mean number of reported delinquent acts also shows a significant reduction over time, but with a much larger variance. By three months, the mean number of delinquent acts is reduced from 5.4 to 2.2, at six months to 2.1 ($t=2.7$, $p=0.02$, $d_z=0.8$), and at 12 months to 1.1 ($t=2.5$, $p=0.04$, $d_z=1.2$).

While the reported change over time is large and statistically reliable, the large proportion of missing data makes interpretation difficult. It is again acknowledged that the COVID-19 pandemic was a significant factor in preventing the completion of outcome measures during the pilot period and that this was a 'before-after intervention' pilot evaluation without a control group. An analysis of missing data is not helpful, as the relatively small sample size and the high degree of missing data means that the error of estimation in the imputed scores will overwhelm any observed effect. The profile of families reporting data, compared to those that do not, does not show any difference at baseline (as reported above). However, it remains possible that families that did not provide data at follow-up were not responding as well to the programme as those families that did provide data. The outcomes, therefore, need to be treated with some caution.

[4] It is generally recognised that an effect size d>0.7 is large. However repeated measures designs, where the evaluation is change over time generally, show larger effects than comparisons between groups in parallel group designs (intervention compared to control groups).

Table 15. Mean score and standard deviation for total SDQ score across each time point

	Baseline n= 62			3 months n= 21			6 months n= 32			9 months n= 18			12 months n= 21			15 months n= 12			18 months n= 3		
Parent	m (sd)	Min	Max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
SDQ total	19.40** (6.98)	4	37	14.67* (7.22)	2	26	11.44 (6.55)	1	30	9.89 (7.59)	4	28	10.57 (6.60)	2	25	6.5 (4.83)	0	16	9.67 (4.51)	5	14
	Baseline n= 68			**3 months n= 22**			**6 months n= 34**			**9 months n= 18**			**12 months n= 22**			**15 months n= 13**			**18 months n= 3**		
Child	m (sd)	Min	Max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
SDQ total	18.12** (6.15)	6	31	12.23 (6.92)	3	27	9.77 (5.77)	0	24	8.44 (4.45)	2	16	8.91 (6.10)	2	24	7.92 (6.47)	2	25	12 (7)	4	17
	Baseline n= 38			**3 months n= 18**			**6 months n= 14**			**9 months n= 13**			**12 months n= 15**			**15 months n= 9**			**18 months n= 3**		
Teacher	m (sd)	Min	Max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
SDQ total	19.24*** (5.62)	9	30	15.11* (7.89)	5	29	9.14 (7.17)	3	28	9.85 (6.22)	1	19	11.20 (9.12)	3	33	5.11 (4.26)	1	15	10 (9.64)	3	21

Note: 4-band solution for cut-off scores of SDQ (rounded to nearest whole number). *=slightly raised than average **=High ***=Very high

Table 16. Mean SDQ impact score and standard deviation across each time point

	Baseline n= 56			3 months n= 14			6 months n=19			9 months n= 12			12 months n= 10			15 months n= 4			18 months n= 1		
Parent	m (sd)	Min	Max	m (sd)	min	max	m (sd)	min	Max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Impact	3.55*** (2.52)	0	9	2.50*** (2.10)	0	6	2** (2.52)	0	8	2.08** (2.68)	0	8	1.90** (1.66)	0	5	0 (0)	0	0	1* (.)	1	1
	Baseline n=60			**3 months n= 16**			**6 months n= 19**			**9 months n= 10**			**12 months n= 8**			**15 months n= 5**			**18 months n= 1**		
Child	m (sd)	Min	Max	m (sd)	min	max	m (sd)	min	Max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Impact	4.33*** (2.01)	0	10	1.44* (1.63)	0	4	2** (2.52)	0	8	1* (1.05)	0	3	0.75* (0.71)	0	2	.4 (0.89)	0	2	1* (.)	1	1
	Baseline n= 35			**3 months n= 14**			**6 months n= 9**			**9 months n=9**			**12 months n=6**			**15 months n= 4**			**18 months n= 1**		
Teacher	m (sd)	Min	Max	m (sd)	min	max	m (sd)	min	Max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Impact	3.06*** (1.68)	0	6	2.36** (1.91)	0	5	0.67* (1.32)	0	4	1* (1.22)	0	3	2.33** (1.86)	0	4	0.25 (.5)	0	1	0 (.)	0	0

Note: The range is 0-10 for parent and child scores and 0-6 for teachers. The 4-band solution for cut-off scores of SDQ (rounded to nearest whole number) has been used. *=slightly raised than average **=High ***=Very high

Table 17. Mean and standard deviation for the SCORE 15 each time point

Parent	**Baseline n = 21**			**3 months n= 12**			**6 months n= 11**			**9 months n= 16**			**12 months n= 13**			**15 months n= 12**			**18 months n= 3**		
	m (s.d)	min	Max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max
Total score	27.33 (8.62)	15	44	25.08 (8.62)	15	36	28.73 (12.59)	15	53	21.06 (5.34)	15	34	22.69 (9.7)	15	47	19.25 (6.18)	15	35	21.67 (6.03)	16	28
Average	1.82 (.57)	1	2.93	1.67 (.57)	1	2.4	1.92 (.84)	1	3.53	1.4 (.36)	1	2.27	1.51 (.65)	1	3.13	1.28 (.41)	1	2.33	1.44 (.4)	1.07	1.87
Child	**Baseline n = 68**			**3 months n= 21**			**6 months n= 34**			**9 months n= 18**			**12 months n= 22**			**15 months n= 12**			**18 months n= 3**		
	m (s.d)	min	Max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max
Total score	34.16 (10.15)	16	64	27.33 (10.8)	15	52	24.47 (8.35)	15	51	21.72 (5.64)	15	34	22.73 (8.49)	15	45	19.42 (6.16)	15	32	23 (8)	15	31
Average	2.28 (.68)	1.07	4.27	1.82 (.72)	1	3.47	1.63 (.56)	1	3.4	1.45 (.38)	1	2.27	1.52 (.57)	1	3	1.29 (.41)	1	2.13	1.53 (.53)	1	2.07

Note. The total score gives a possible score of between 15 and 75, and the average score gives a possible score between 1 and 5.

Table 18. Mean and standard deviation of the Cries-8 scores and ESYTC number and frequency of reported acts across each time point

CRIES-8	Baseline n = 5			3 months n= 22			6 months n= 34			9 months n= 16			12 months n= 21			15 months n= 12			18 months n= 2		
	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max
Total score	6.00 (13.42)	0	30	9.95 (9.77)	0	26	10.21 (11.16)	0	34	5.69 (8.23)	0	23	5.24 (8.87)	0	28	6.83 (13)	0	35	10 (11.31)	2	18
ESYTC	**Baseline n = 43**			**3 months n= 18**			**6 months n= 20**			**9 months n= 18**			**12 months n= 22**			**15 months n= 12**			**18 months n= 3**		
	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max
Acts reported	5.42 (4.65)	0	17	2.22 (2.44)	0	7	2.05 (2.68)	0	9	.94 (1.66)	0	6	1.09 (1.95)	0	7	.33 (.65)	0	2	1 (1)	0	2
Frequency	2.44 (1.28)	0	4.82	1.77 (1.71)	0	6	1.63 (1.63)	0	6	.97 (1.28)	0	3	.84 (1.2)	0	3.25	.58 (1.08)	0	3	1.33 (1.53)	0	3

Note 1: The CRIES-8 produces a total score with a cut-off of 17 being a reliable indication of possible PTSD

Table 19. Estimation of outcome and treatment effects (comparison to Time 0), months three and six

Outcome measure	Total n	Baseline			3 months			Comparison 3 months - baseline					6 months			Comparison 6 months- baseline				
		N	m	sd	n	m	sd	N	diff	t (p)	d_z	CI (95%)	n	m	sd	N	diff	t (p)	d_z	CI (95%)
Parent																				
SDQ	169	62	19.40	6.98	21	14.67	7.22	21	2.24	1.65 (.12)	.36	-.60 – 5.07	32	11.44	6.55	31	8.93	7.25 (<.001*)	1.30	6.42 – 11.45
Score-15	98	21	27.33	8.62	12	25.08	8.62	10	1.8	.68 (.5)	.21	-4.21 – 7.81	11	28.73	12.59	4	3.50	.37 (.07)	1.32	-.71 – 7.71
Child																				
SDQ	180	68	18.12	6.15	22	12.23	6.92	22	3.77	2.61 (.016*)	.55	.78 – 6.77	34	9.77	5.77	34	7.94	7.44 (<.001*)	1.28	5.77 – 10.11
Score-15	178	68	34.16	10.15	21	27.33	10.8	21	2.33	1.10 (0.28)	.24	-2.08 – 6.75	34	24.47	8.35	34	11.03	6.49 (<.001*)	1.20	7.57 – 14.49
CRIES-8	112	5	6.00	13.42	22	9.95	9.77	0	-	-	-	-	34	10.21	11.16	0	-	-	-	-
ESYTC	136	43	5.42	4.65	18	2.22	2.44	16	2.69	3.28 (.005*)	.74	.94 – 4.44	20	2.05	2.68	15	3.87	2.66 (.019)	.87	.75 – 6.98
Teacher																				
SDQ	110	38	19.24	5.62	18	15.11	7.89	13	4.46	2.62 (.02*)	.73	.76 – 8.17	14	9.14	7.17	10	9.8	4.91 (.001*)	1.55	5.29 – 14.31

Note: * indicates a significant difference at a .05 level

Table 20. Estimation of outcome and treatment effects (comparison to Time 0), months nine and 12

Outcome measure	Total n	Baseline			9 months			Comparison 9 months - baseline					12 months			Comparison 12 months- baseline				
		N	m	sd	n	m	sd	N	diff	t (p)	d_z	CI (95%)	N	m	sd	N	diff	t (p)	d_z	CI (95%)
Parent																				
SDQ	169	62	19.40	6.98	18	9.89	7.59	16	10.94	4.83 (<.001*)	1.21	6.11 – 15.76	21	10.57	6.60	19	8.95	3.21 (.005*)	.74	3.08 – 14.81
Score-15	98	21	27.33	8.62	16	21.06	5.34	5	-1	-.39 (.72)	.17	-8.19 – 6.19	13	22.69	9.7	2	-9	-.64 (.64)	.45	-186.87 – 168.87
Child																				
SDQ	180	68	18.12	6.15	18	8.44	4.45	18	9.56	6.01 (<.001*)	1.42	6.20 – 12.91	22	8.91	6.10	22	10.86	6.75 (<.001*)	1.44	7.52 – 14.21
Score-15	178	68	34.16	10.15	18	21.72	5.64	18	13.33	4.93 (.001*)	1.77	7.63 – 19.04	22	22.73	8.49	22	15.41	4.84 (.001*)	1.58	8.79 – 22.03
CRIES-8	112	5	6.00	13.42	16	5.69	8.23	0	-	-	-	-	21	5.24	8.87	0				
ESYTC	136	43	5.42	4.65	18	.94	1.66	13	6.31	5.14 (<.001*)	2.02	3.63 – 8.98	22	1.09	1.95	8	4.75	2.52 (.039*)	1.17	.31 – 9.19
Teacher																				
SDQ	180	68	18.12	6.15	13	9.85	6.22	8	9.12	4.57 (.003*)	1.67	4.41 – 13.84	15	11.20	9.12	9	6.44	2.31 (.04*)	.77	.012 – 12.88

Note: * indicates a significant difference at a .05 level

Table 21. Estimation of outcome and treatment effects (comparison to Time 0), months 15 and 18

Outcome measure	Total n	Baseline			15 months			Comparison 15 months – baseline					18 months			Comparison 18 months- baseline				
		n	m	Sd	n	M	sd	N	diff	t (p)	d_z	CI (95%)	N	m	sd	N	diff	t (p)	d_z	CI (95%)
Parent																				
SDQ	169	62	19.40	6.98	12	6.5	4.83	11	13.27	3.53 (.006*)	1.06	4.89 – 21.65	3	9.67	4.51	2	7.33	1.34 (.31)	.77	-16.28 – 30.94
Score-15	98	21	27.33	8.62	12	19.25	6.18	0	-	-	-	-	3	21.67	6.03	0	-	-	-	-
Child																				
SDQ	180	68	18.12	6.15	13	7.92	6.47	13	13.08	5.41 (<.001*)	1.50	7.81 – 18.34	3	12	7	3	5.33	2.22 (1.6)	1.28	-5.01 – 15.68
Score-15	178	68	34.16	10.15	12	19.42	6.16	12	21.17	7.21 (<.001*)		14.71 – 27.63	3	23	8	3	12.33	1.86 (.20)		-16.24 – 40.91
CRIES-8	112	5	6.00	13.42	12	6.83	13	0	-	-	-	-	2	10	11.31	0	-	-	-	-
ESYTC	136	43	5.42	4.65	12	.33	.65	2	6.5	1.18 (.45)		-63.37 – 76.38	3	1	1	0	-	-	-	-
Teacher																				
SDQ	180	68	18.12	6.15	9	5.11	4.26	2	12.5	8.33 (.08*)	5.89	-6.56 – 31.56	3	10	9.64	0	-	-	-	-

Note: * indicates a significant difference at a .05 level

The interviews may also be useful to elucidate outcomes. Despite initial intentions, it was not possible to rate and quantitatively compare progress on goals. This was because information on goals was so individual, somewhat incomplete, and could include matters beyond the scope of this intervention. How goals were set and monitored is considered in more detail under the evaluation of the implementation process within Aim 6. Here, one excerpt is drawn on to elucidate how young people felt about the use of goals, considering it was self-affirming, particularly as they had seemingly exceeded the practitioner's expectations:

> *"Like the way I think of things* [has changed]*. A different way to see life […] Well, they* [mentors] *show you a better way. There's more to life.* [The] *first time he* [mentor] *met me, well, there's no change; he ain't going to change. And, I've surprised them"* (Young person #3).

A recurring theme derived from interviewees was how programme involvement had led to better communication styles adopted by young people. Parents and carers emphasised the positive impact this had on family life:

> *"I think there's definitely improvement because he wants to kind of be with the family now. [...] He seems a bit more open about certain things, and he doesn't want to shut himself away as much. We try and involve him in chats, and things like that" (*Parent/carer #1*).*

> *"I think the family are quite surprised that he'll join in the conversation and play a game at the table and joke around with them, and play. [...] I think before that, he didn't really speak much at all."* (Parent/carer #3)*.*

Professionals also noticed indications that a developed ability to communicate with others could lead to a young person gaining a sense of increased trust and security towards adults at home and school:

> *"*[The] *foster carers always talk about how much his* [young person] *communication has improved, and, actually, the school said that the other day.* [Before] *Guiding Young Minds were involved,* [he] *just wouldn't go to school, and when they spoke to him, they couldn't have a, I suppose, a sit-down conversation where things were calm. So, I'm told that his communication is far better than when he first came into care and that his emotions are better regulated. […] And that's quite major, given what he has been involved in since he was 11; so he'll be 15 in June"* (Social work professional #1)*.*

> *"I've had headteachers say to me before, 'Oh, I haven't had one word said to me from this child in two years, and then I've just had a whole conversation with them.'* [They're] *opening up at home, or they're engaging in lessons, or they might be getting involved in group activities that they might have pulled themselves away from and avoided before. Or they might be turning up to a teacher's office and going to have a conversation with them when they've had a bad, hard day"* (Practitioner #2)*.*

Another parent/carer echoed these improvements, noting how important the mentor had been to the process:

> *"And he's talking* [about] *the people he knows and things what go on, and do you know what? I thought I knew what goes on in the streets, well, it just goes to show that I am getting old because I was shocked[*...]*He does have down days where he's like, 'I can't do this.' And I'm like, 'I'll send a message to* [practitioner], *and* [they] *will reach out to him.* [A] *lot of it is private and confidential;* [young person] *opens up about personal things, but he like picked himself up and went, '[…] it's just a bad day, not a bad life.' And I was like, 'That's better!'"* (Parent/carer #5).

Other parents and carers identified the mentor relationship as having helped to rebuild relationships within the family home. A finding consistent with the premise of wraparound support, with professionals working to help ensure young people sustain good relationships with their families, including other siblings as well as caregivers.

> *"I went from a very bad relationship with my son to being almost best friends again, which is lovely, and that I can't thank* [mentor] *enough, really"* (Parent/carer #3).

> *"*[Once] *he'd been there [...], albeit for only about two days, he was calmer,* […] more *relaxed, more determined to go on the right path.* [He] *would push boundaries, really push boundaries. And it did cause a little bit of conflict within my own family because I have my youngest son still living here, and he used to get upset at how I got disrespected. But it was nice to know that on a certain day, he could go and offload about how he was feeling. He actually apologised to my son and said, 'Look, I shouldn't have done that, I shouldn't have said that, and I'm sorry [...]' So it helped him realise that also not where he was going on the right path, but also what he was doing wrong"* (Parent/carer #1).

There were other indications that young people's improving ability to explore their thoughts and feelings with adults, including professionals and family members, had enhanced their well-being:

> *" ..They tend to bottle everything up, and they don't talk to anybody at home, they don't talk to anybody at school, they don't talk to friends. And then over time, when they suddenly come in one day and they're chatting away, and then they might say, 'Oh, I opened up to a teacher today and told them everything, and then I've been talking to them on a weekly basis since then.' Or 'I might have opened up to a sibling at home.* [Through therapy], *they've started that gradual exposure; they've started talking about a really difficult subject, and it's just made them feel safe and comfortable to start talking and opening up about other things with other people. And I find that really significant and positive"* (Practitioner #2).

Practitioners reflected on how they would encourage family involvement, the impact of which meant that young people were supported to 'open up' to parents or caregivers about their experiences. In turn, this encouragement helped protect young people's emotional well-being during therapy, including with traumatic memories.

> *"*[Family involvement] *works really well because it kind of helps with the gradual exposure, especially to the trauma, you work through the gradual exposure as you go through each session. And then if you were to bring in a family member to that as well, that then helps when your sessions come to an end because they've opened up the communication and started talking about their trauma with a member of their family at home as well. So, it helps to continue the exposure to the trauma"* (Practitioner #2).

Enabling young people to 'open up' to adults also potentially helped safeguard young people in the community, as a practitioner observed with respect to one referral:

> *"I remember one parent was actually shocked* [by referral] *because that was a girl, a young girl, and she had done brilliant in school, but* [she] *was* [involved] *with some gang member. So, she was in high risk of being groomed* [and] *the parent was not aware. So, we encouraged open discussion or conversation between the parent and the child, and that eventually happened"* (Practitioner #3).

Young people's capacity to 'open up' to adults and rebuild family relationships also enhances a sense of familial belonging beyond their former peer group or associates.

> *"They're respecting their parents. They're taking more time with themselves and thinking about the choices that they're making. Their friendship circles change, and their self-confidence and belief in themselves*. *Belonging becomes a place where they have found their belonging in themselves, instead of trying to find* [it in] *other people"* (Practitioner #1).

A dominant theme across interviews was the notion that young people had developed the resilience needed to steer away from or end negative associations.

> *"*[We've] *had plenty of people and parents, and providers that have been through the programme and said* [they've] *seen that behavioural change, they've seen that maturity, and they've seen that their friendship groups have changed, and their attitudes and behaviours are improving"* (Referrer #2).

> *"… He wouldn't go out the house; he just kept himself away from that situation, I think. Fair play to him, and I think that's quite a hard thing to do […] He said to me, these are friends that I've grown up with and gone to school with…"*(Parent/carer #3).

> *"I was just like really vulnerable to join a gang […] it's got me distanced away from the people now, and trying to focus me in the right way"* (Young person #1).

> *"*[My] *life was just all to do with making money, not living, just going around everywhere, just trying to make as much money as possible. But now I've realised life really ain't about money, it's more about the people around you and everything [...] and the environment you're in"* (Young person #2).

One parent/carer provided an example highlighting how the mentoring relationship had provided the strength and presence of mind for a young person to move away from a concerning situation:

> *"He was in a situation where he was in a town, and there was a group of lads, and they confronted him. [I] can't explain these days; it's like they want to be little gangsters. There's no other way of saying this, but all the kids, they've got a reputation. So, normally, I would say that he'd* [young person] *probably lash out, do this, do that, I don't know, but he didn't. And he said, 'I can remember what my mentor said to me. It's either fight or flight, so I ran.' And he ran to the nearest shop and rang the police"* (Parent/carer #5).

Aim 5: Evaluation of success criteria

Bias in the screening and referral process [Green]

The referral and screening appear to be unbiased based on the demographic data available at that stage. There is very little observed difference between young people who are enrolled on the programme and those who are not. The young people who are not enrolled tend to report fewer problems and are less likely to be referred by agencies. This indicates a robust process that is suited to undertaking a larger-scale trial.

Retention of young people in the programme [Amber]

The programme did not report the number of sessions attended by young people, as originally intended, but did report the number of young people completing the programme. The proportion completing the programme was quite high (68%). While there is potential bias in reporting by the programme, there was little indication that this was the case. It should be noted that both duration and intensity of intervention could have varied by extending mentoring and wraparound sessions. Thus, the proportion of intended and actually completed sessions should be more stringently recorded and reported if a trial were to proceed. However, there can be confidence that a decent proportion of young people enrolled on the programme will complete it, and all else being equal, this would tend to support a larger trial.

Sufficiently robust and unbiased data completion [Red]

Data completion was a significant problem. While it is acknowledged that the COVID-19 pandemic was an issue, the maximum proportion of data completion at any time point was 46%, which is very low and compromises the internal reliability of any study design. There was no indication that there was a significant difference between young people who did or did not have completed measures. However, it is also possible that young people without completed measures were not responding to the programme as well. There is no way to evaluate this possibility. This issue remains a significant risk to a future trial.

Can a trial of sufficient magnitude be delivered? [Amber]

The programme produced a significant before-after treatment effect for young people where outcome data were reported, indicating that there is good evidence that the intervention could be effective in a randomised trial with at least a medium effect size. The exact effect size of a likely randomised parallel groups trial will depend on a number of factors that can only be properly addressed when a design is fully specified, including, for example, the comparison group. If we assume that the primary outcome is the SDQ (as reported here) and a plausible 'treatment-as-usual' group can be specified, it is reasonable to assume an effect size (between groups) of d'=0.5. With an effect size of d=0.5 (α=0.05, 1-β=0.9), the required sample size per group is 70. This would need to be considered in the context of completion of the intervention (68%) and data completion, which would significantly increase the required sample size.

The programme recruited a significant number of young people to the intervention over a year (n=74), indicating that families are willing to engage. How many of these families would be willing to take part in the randomised trial with random allocation is unclear. There remains the potential to complete an appropriately powered trial given the potential to recruit to the programme, but it is likely that either the current programme would need to increase capacity, or other sites would need to be identified.

The primary risk to a trial must be the lack of data completion. The impact of the pandemic needs to be considered, but even under these circumstances, the level of data completion is low. A number of issues would need to be addressed to recommend progression to a full trial.

1. Can sufficient evidence be gathered to indicate that data completion can be improved?
2. Can a suitable control intervention be identified that is not subject to too much heterogeneity?
3. Evidence would need to be gathered to indicate that families would be willing to be randomised.

If these issues can be addressed, it is likely that a trial of sufficient magnitude can be delivered.

Aim 6: Implementation process

Interviews were completed with eight professional stakeholders. These stakeholders included two practitioners from referral agencies, one ASSIST GYM staff member, four ASSIST GYM practitioners engaging in direct work with young people, and one social work professional of an involved young person in foster care. Service users who participated in interviews included five young people and six parents or carers of involved young people. Consideration of Aim 6 will be presented in four broad subsections: implementation fidelity, engagement, responsivity, and unforeseen or other findings.

Implementation fidelity

In line with the universal element of ASSIST's work, community outreach was used to encourage willingness to participate in GYM. This included travelling to communities in the ASSIST customised vehicle, seeking to increase awareness:

> "[When] *you're out in the community, and they recognise who you are, and they will ask questions: 'How do I get you to come to my school?' or 'How do I get my friend to link up with you?', in the sense of being able to help them. And even from parents as well, to be fair, and just members of the community that walk past sometimes that see our van when we're out in the community.* [It's] *very powerful, in the sense that it creates a lot of curiosity, and it comes from all age groups.* [You're] *able to engage with them.* [I] *think having that presence as well, also helps being recognised and people are getting know us in different avenues, and it helps*" (Practitioner #4).

This practitioner also emphasised that they have found community outreach helped break down barriers with young people and increase interest in the programme, which, it is suggested, offsets the potential for vulnerable young people not to access the programme:

> "[Sometimes] *they will get in contact with us directly, and it could be that, actually, they were referred to us through school, for example, and they've said no. And then we've gone to the school because we've done a workshop or an assembly about knife crime and gangs, and so on and so forth. And actually, they remember us, and because they get to see us almost like in a different context, and they're able to engage with us that way.* [They think], *'Actually, hmm, maybe actually I can speak to them. They do know what they're talking about. I do feel like I could potentially trust them,' and then they approach you*" (Practitioner #4)

The holistic approach taken within GYM included putting in place opportunities to help young people meet future-oriented goals, such as those relating to education or careers:

> *"One of the things that we're starting to do is starting to sort of take apprentices or take the youngsters out with us when we go to schools and tell their story, which makes a huge impact on those who are listening. But it also helps that young person, it like gives them some value.* [We] *want to start working with organisations who are prepared to take them on, trust them, give them apprenticeships, give them jobs. We've got to work with all those things to give them a future"* (Staff member #1).

The opportunity to set goals comes through in the interviews as being key to the programme in supporting young people to identify what they would like to change in their lives. Goal setting is incorporated into direct work as a therapeutic method of helping young people work towards their identified goals and change. This

specific element of the programme helps focus young people's minds on their own potential, supporting them to recognise change as they progress through the programme, as emphasised by a practitioner and two young people:

> *"*[We're] *able to work together in order to get them to a better place. They're able to identify what they feel is problems and issues that's holding them back, and I'm able to work with them on those goals"* (Practitioner #5).

> *"*[My difficulties] *was just having gang ties, and then misuse of drugs and alcohol and stuff like that. It just put a little bit of like, what's it called? A bit of sense into my head"* (Young person #2)

> *"Normally* [during sessions] *we set goals, like what we want to do when we're finished school and everything, but not really for the week. We mainly talk about what I want to do with my life"* (Young person #5).

Although not set in ways that could rate progress against a standardised measure, the comments fields in the survey database showed that young people had set goals around the following themes: a wish to understand their own behaviour, change negative behaviours and 'be good'; wanting to alleviate feelings of anger and better manage negative emotions; to open up to others about feelings and be supported with past trauma; to stay away from associates they identify as a negative influence in their lives; to feel safe and learn how to help keep them safe; and to improve school attendance, achieve in education, and work towards a chosen career. Parents/carers identified goal setting as a mechanism to encourage positive change:

> *"I hoped it would keep him on the straight and narrow* […]; *he'd got this fascination about being part of a gang. [I] think it sort of just made him realise that, no, that wasn't the way to go and plan your life, and there were better ways of spending his time"* (Parent/carer #1).

Setting goals focuses communication between mentors and young people and helps in identifying positive outcomes through the process of reviewing progress:

> *"[We] write it all down, and it goes on like a star sheet, and throughout the weeks, if there's things that are digressing, or progressing, every session, we recap on the last session, and then we build on it. And when it comes to six weeks, we then recap and summarise what happened. And then most of the time, the progress grows"* (Practitioner #1).

It was recognised that, at its best, mentors could be seen following up on goals. It was also reported that, in line with the intervention aims, practitioners worked in various settings to build and sustain relationships with young people:

> *"[The mentor] did try to look into some additional experiences for* [a young person]*, so work experience. They had talked about [*mentor*] supporting him to get a part-time job, and that kind of thing"* (Social work professional #1).

> *"[GYM] helped me out, like, guiding me […]; getting me away from them people. When he's [mentor] coming out and seeing me, like doing school […] and then when I'm at home taking me out [...] They would take me to the sports hall to play football and all that"* (Young person #1).

One practitioner had reflected on how affirming it was, during a review of progress with young people, to recognise positive change:

> *"*[For] *them to be able to see it* [change] *for themselves and to recognise it, and the people around them to be able to give them positive feedback […], I think that enables them.* [They] *feel encouraged; that actually what we're doing, it's working for them, and it's paying off"* (Practitioner #4).

One of the challenges to implementation fidelity was in managing the scale and scope of referrals:

> *"*[We] *try and put these people in touch with someone we know in their area. A few times, people have said, 'Can we bring them to you?' Social workers, in particular, are very desperate social workers and will say, 'we'll put them in the car and bring them'. But as you probably know from looking at the data, we're not working with these kids for six weeks; it's quite a lot longer, so there's a big commitment on time and finance to do that…*[The] *majority of the appropriate referrals are from schools and the police. Because we're able to explain to them what the criteria is, and they understand it. Whereas we get lots of referrals from other places, but they don't really understand the criteria […] Quite often we have to say 'no', and they say, 'Well, I thought that was probably the case, but we thought we'd just try our luck'"* (Staff member #1).

The ASSIST GYM team rapidly recognised the need to be clear on referral thresholds. Also, to ensure that mentors are not expected to work beyond their capacities. In staying true to the intervention's intentions, it can be hard to reach a balance. For example, putting in place restrictions on accessing mentors might limit the programme's reach and potential impact on vulnerable young people:

> *"*[Probably] *a lot of professionals would say you shouldn't be doing that; you should be putting in boundaries. And to some extent, I agree with that, and I sometimes say to the mentors, just be careful because they're going to push and push and push, and the more you give, the more they will push. So, we are trying to be careful about that; however, we are also aware that these are kids who have got no relationships, and very often,* [there] *are attachment difficulties.* [They] *feel nobody has ever cared about them, and suddenly* [they] *found someone that does"* (Staff member #1).

Considering how best to build and sustain engagement with young people within such parameters is the focus of the next section.

Have service users been engaged?

All interviewees – professionals, parents or carers, and young people – placed significant emphasis on the quality of mentor-young person relationships to achieving positive outcomes. Families highlighted how relatable mentors are to young people referred to the programme:

> *"They just know, like, what it's like to be like naughty and that, because they've all done it, so […] they just understand you, and they're just good to speak to"* (Young person #4).

> *"I believe* [mentor] *had been involved in the past in gangs and had pulled himself out of it. And I think it's more like, 'If I'd have had somebody to guide me, I may not have* [got] *into that situation,' which he always impressed on the child in my care that you do not want to go down this path because it ruins your life and everything. And, like I say, he was always there for him"* (Parent/carer #1).

To sustain engagement, professionals also recognised the importance of relatability and credibility of the staff. Such engagement seemed to be providing a non-judgemental space for young people to share their experiences and concerns:

> "[Young people] *can speak far more freely about their experiences to someone who can genuinely understand and empathise, rather than just sort of understand and comprehend.* [That's] *a massive difference, compared to just your conventional life coaching or mentoring, by having an organisation like GYM who has got those genuine lived experiences and local connections. It's not like he's from miles away; he is still quite local and knows a lot of people, and I think that's what makes them stand out as an intervention*" (Referrer #2).

The importance of non-judgemental support for young people was echoed by a parent/carer and young person:

> *"*[I] *think it kind of dawned on him that what he'd done was wrong and shook him up a bit.* [GYM] *were very supportive to* [young person], *and they weren't blaming, you know what I mean? They were understanding, and I think that's the key thing; you've got to understand and support, and guide them again, learn, teach them*" (Parent/carer #3).

> *"So, you're not just chatting to some bloke up the road.* [They] *used to be in the same* [situations], *then they've obviously changed, and now they're trying to help other people change, [...] which you can relate with, makes it a lot better*" (Young person #3).

Another young person emphasised how mentors had become role models in their lives, which encouraged their progress through the programme:

> "[At] *first, I thought it was just like a therapy session type thing, but then I realised this is not; it's like the complete opposite. It's like, yeah, there is those parts to it, but it's like you're talking to your mate, really.* [I've] *had mentors before that have just tried, like, what's the word? Brainwashing you. But then with* [mentor], *he doesn't try brainwashing you; he just tells you what's what* [...] *He would tell you what's going to happen if you do this, if you carry on.* [He] *does say, at the end of the day, it is your decision on what you do, but, at the same time, he comes from a perspective where I can understand it.* [He's] *a good role model to look up to, if you know what I mean?"* (Young person #2).

Adults in the families felt that the comparatively generous time allowed meant that young people had space to develop trust in practitioners. The consistency of mentoring was particularly emphasised as valuable to maintaining engagement:

> "[Unfortunately], *this child, in particular, had had 14 different social workers.* [He] *feels very let down because of all the different changes.* [The mentor] *was a constant, and that helped tremendously*" (Parent/carer #1).

> "[My] *son doesn't like lots of different people coming and coming going in his life [...] So it was just finding somebody that he could kind of connect with*" (Parent/carer #4).

Practitioners underlined how they were not working within a tight intervention window and could take time to foster relationships with young people:

"So, under the YEF, it was kind of open-ended sessions, and we can work with the client until we feel that they're ready to end, and that's open-ended [...] Whereas with other types of funding that we might receive, you might be more restricted [...] And you've got to spend time building that relationship and building that therapeutic relationship before you can then start working through anything" (Practitioner #2).

Importance was placed on not retracting support prematurely so that young people are not left feeling unsupported. In recognising that engagement needs to end, practitioners were keen to taper support and sought to ensure that young people would stay mindful of their developing resilience:

"[When] *it gets to a certain time where say, the police are happy he hasn't reoffended. The social worker says that he's fine, and they've disengaged with him because he's doing fine. The welfare says that he's good, and teachers say that's because that's where we say to the child, you are at a time now where you're doing well; we will be now starting slowly fading away from you.* [We're] *a service that we encourage them, and we say to them, we're here to help you, but you've got to do the walking. So, when our work is done, they're strong enough to go on their own, but they still remember if they need a little support or advice, they can still call us"* (Practitioner #1).

Is the intervention responsive?

When considering responsivity, it is important to evaluate whether service users feel they were responded to and if the context of their situation was acknowledged appropriately. Those who work with an intervention, such as referrers or other stakeholders, should also feel comfortable with how a programme team responds to them. During the delivery of GYM, creative responses were made to the additional restrictions imposed in response to COVID-19. The GYM team made use of social media as a tool to both raise awareness of the programme and engage young people in the idea that the programme may benefit them. The team also produces videos, publishing them on social media to reach young audiences. These are also used by referring schools:

"[We] *put messages in our own films, and we bring people in that relate to the kids. And so that we've got a very, very high following on our social media, and a lot of schools use our videos and our content in their assemblies"* (Practitioner #1).

"I use them for my PHSE, and I use them for high-level intensity, for children who are on the verge of falling fast [...] I have what I need, and if I need anything else, I just touch base with [a mentor], [he may say] *'I'll have a think about this, or we can do something on that, I'll create something.' Or he'll send something through for the kids, so he sent his new theme tune;* [a] *real funky little rap that he'd done. And we shared that with the kids."* (Referrer #1).

As the previous extract demonstrates, much of this material has been created specifically in response to teacher requests. New films and media have been tailored to the personalities and needs of involved young people to maximise participation. There is indication that when providing focused support, practitioners take care to respond to young people's individual preferences:

"So it could be that one particular young person engages a lot better [through] *activities. Another one, it's through direct work and completing pieces of work, so to speak, in the sense of printed forms*

[...] Whereas with others, it's more of a conversation and dialogue. So, you do adapt differently to that individual, despite the fact that you're delivering the same piece of work" (Practitioner #3).

Moreover, the chosen environment also has significance to participation in direct work, for example:

"[We] *do a lot of activity-based things.* [It's] *not necessarily just in a room; it can be out in the community, in the park, in the home, if they feel comfortable to have their sessions at home. It's identifying that space in which they will thrive in and which they will work best in. Each individual is quite different* [...]" (Practitioner #4).

Additionally, practitioners have found that a range of group-oriented activities helps increase participation:

"[The] *group work was absolutely fantastic. And we're still carrying on some of that because we were doing a whole range of things. We were doing podcasts, we were getting speakers in, we were doing questions and answers, and we're putting lots of competitions. So, we were doing […] different games and sports competitions, and singing competitions and dancing competitions, and all sorts of things that kept them engaged, and they wanted to come back next week to see who won"* (Staff member #1).

Parents, carers, and young people recognised the impact of creative delivery on continued involvement in the programme:

"[They] *helped him engage with his music and sports to try – well, boxing, mainly – to try and guide him, to control his anger, and mentor him in that way; because he was drifting towards gang*[s]*, so it kept him occupied. But this child also liked his music, and they turned up one day in the van with some decks and that, so he could record some music"* (Parent/carer #1).

Responsivity was also demonstrated in the sometimes intricate relationships developed among professionals and other agencies in supporting young people. Practitioners also underlined the importance that they do not break the confidentiality of young people when needing to share information with other professionals:

"[When] *the referrals come over, my first port of call is to obviously speak with the referrer to get an idea of what's going on and what the situation is. And as the intervention continues, I will continue to liaise with the referrer.* [So] *certain conversations about certain topics will be had with the referrer so that they can put something in place that, again, would benefit the young person"* (Practitioner #4).

"[At] *the minute, the police react to everything, and they get called out with everything, and that's why* [they] *haven't got the resources to do everything, but now we're working with them, to let them know that there's certain things they don't have to do. There are services that can do it, and that's how we're working with them"* (Practitioner #2).

The support networks and creative ways in which they were maintained extended to how mentors engaged with teaching staff within the schools in which they operated, potentially drawing families into becoming better engaged with schools as well as other services:

"[The mentors] *always work with the children and their teacher.* [They] *are both well-known in school because it's a programme of work that happens. […] The teacher gets to know them, and we always*

– it might be a right thing or a wrong thing – we always send them down with their books, their learning books as well. [The mentors] *get a chance to have a look at what they're doing.* [It's] *just this kind of invisible ring around the child [...] Parents sometimes come into school as well, to see them"* (Referrer #1).

"[The mentor] *and I always talk about how close the professional network is, and if something happens,* [we're] *relatively quickly updated.* [We] *really have to keep in touch and in close contact to try and get to the bottom, I suppose, of what is actually going on* [with young people]. [In] *professional meetings as well, the advice and the insight that they can give has been invaluable "* (Social work professional #1).

Interviewees stressed the importance of delivering a programme that was responsive to the requests of referrers and identified needs of young people:

"It all depends on the risk of the child. [The] *higher risk they are, the more influence they are to the community, and that's when we're more involved. So, there's a different package for individual families.* [You] *have to tailor the support to each child because every family is different"* (Practitioner #1).

"[They] *made time for him and listened to what he wanted [and] tried to facilitate that as best they could. Because a lot of these organisations is, 'Oh, this is what we do, and we're not changing anything.' Whereas I think with the ASSIST programme, they more melded into what kept him focused, as opposed to what they offered"* (Parent/carer #1).

Families also appreciated the flexibility offered with ongoing potential contact:

"[Young person] *is still not part of it, but I think he still has telephone contact with [...] his mentor. So, it's not a case of out of sight, out of mind"* (Parent/carer #1).

"They're just checking up every now and then […]; they're a good help" (Young person #3).

"I speak to him [mentor] *every now and then; telling him how good he is towards me […] He says that he's noticed me not hanging around with them people no more, and not causing any trouble"* (Young person #1).

Interviewees seem to have identified that wraparound approaches were leading to readily accessible support beyond formalised sessions:

"[The mentors] *are making a difference. And the fact that the days that they would come into school, the children would attend school because they knew that* [mentor] *was coming, or they knew that* [another mentor] *was here. Sometimes the children would come* [to] *me and say, 'I've got a problem, can you call* [mentor]*?' 'Well, is it a proper problem?' Yeah, it's a proper problem.' And I would call* [mentor] *and say, 'Can you touch base?' And he would."* (Referrer #1).

"Just having someone there to speak to all the time, really. *Like,* [the mentor]*, whenever I need him, I can text him and like it will be all right"* (Young person #2).

It was also noted by adults with parental responsibility that GYM practitioners are sensitive to the needs of young people when it comes to how they communicate their support, particularly at times when young people were in difficult situations or upset:

> *"No matter what time, even if it's at night, he can always send a message.* [If] *he's out with a group of friends and there's trouble or something is going to kick off, or if he's in a situation where he wants to get out, but he doesn't know how to, then he sends a little emoji text message to them. And then they'll ring up, and then they'll say, 'Oh, you need to come back because this has happened,' as if it's like an emergency that he needs to come back to get him out of that situation. And I'm like, wow, that's quite clever"* (Parent/carer #5).

The extract above indicates how support strategies can also be adopted, ones which families may choose to continue, having seen their utility. Parents or carers, too, placed value on how accessible they found the practitioners:

> *"*[They] *supported me as well. Sometimes, I'm struggling* [and] *even I can send them a message and they're there as well. They take on quite a lot because obviously they're only meant to be helping* [young person]*, but they've become not just his friend, they've become a family friend"* (Parent/carer #5).

Furthermore, a referrer and practitioner stressed the importance of maintaining accessibility to enable them to seek or provide valuable support to young people:

> *"*[We] *have the 24-hour number for parents to ring,*[...] *It's not even just parents, there's professionals* [of] *kids that we work with as well; that are in the police, that are in the social services, and a lot of them, they find it hard because they work with that sector, they feel it's shameful to have a child like that, but it's not"* (Practitioner #5)*.*

> *"Recently, we would – those that were 10–14 – we would refer through* [to ASSIST GYM] *for trauma therapy.* [We] *would refer through for those ones that were the really high-risk ones at a young age, that we could see were going to really spiral.* [The] *feedback from that was brilliant. To have that at our disposal as a referral mechanism was just invaluable to get that level of support, where through traditional NHS methods, you're potentially looking at a year to a year and a half wait time to get that sort of support in place "* (Referrer #2).

It was recognised that parents or carers can readily access support from GYM practitioners who provide guidance on young people's difficulties. How practitioners make themselves available for parents or carers was highlighted by different professional stakeholders:

> *"*[If] *you've not been through it, I think it's quite difficult to understand and advise. Whereas [the mentor] does obviously have that background, and he's been through it himself […]* [They] *really value the support as well from Guiding Young Minds. And to know that there's somebody there when he goes missing, when they're worried that* [a young person's] *been taking drugs, to know that there's somebody there that can kind of deal with that. Because I think sometimes for foster carers,* [they are] *just sort of out of their depth, really, with stuff like that"* (Social work professional #1).

> "[We] *made our parent booklet and the 24-hour helpline so people can ask for advice because sometimes people get scared to ring the police […] So when they ring us, it comes from* [the] *sense*

where, well, if GYM is telling us that we need to ring the police, then it's good to ring the police" (Practitioner #1).

"[Once] *I have* [the mentors] *working on a child, they are an email or a phone call away. And as soon as there's anything that troubles me, it's a triangulated response, and they're picking up that information and dealing with it"* (Referrer #1).

Unforeseen and other findings

One of the unexpected positive findings from interviews related to the attempts to target young people who were seen as a negative influence on others. This was related to being able to acknowledge change in oneself as well as in others. A practitioner also observed that recognising change may subsequently increase young people's perceptiveness to challenges experienced by peers and redefine their status towards becoming a positive role model:

"[Change is] *not only something that they feel, but they can also pass on to somebody else; they can be a role model for others to say, 'Well, I was in this place* [and] *if I can do it, you can do it too.' So, I think that's quite powerful within itself, too"* (Practitioner #4).

This section now turns to other findings that do not fit neatly within the key questions for this aim but which were not unforeseen. These often relate to barriers experienced by practitioners and/or young people and their families. Such barriers may have an influence on all elements within Aim 6. Contextual risks are commonly identified as a barrier to intervention. In this instance, the programme is largely delivered in schools, but risks continue in contexts outside and in-between young people's schools and homes. These contextual risks were raised by parents as permeating concerns throughout the intervention:

"[There] *were outside influences around the estate.* [Unfortunately] *because* [young person] *only saw them once a week, after two or three days, he'd drift back towards the people that they were trying to keep him away from. But then, when he saw them again, he would come back more positive and can-do attitude and that.* [Then]*, after about two to three days, once he'd got the influence of these other youths, he would drift back*" (Parent/carer #1).

"You can't stop him not to go out; this is the thing. And he goes out, and he doesn't know what he's doing out there. He doesn't know the kind of people he associates with because, at first, he was into [...] gangs and then some groups. You're living in [area]*, you went to join a gang [...] fighting against* [another]*. You see how dangerous it is?*" (Parent/carer #2).

Practitioners also indicated that gang-involved young people may need to be moved to another area as part of a safeguarding decision. This could then stop engagement with GYM:

"[It] *was very frustrating because we were working with a child, and it was very difficult to engage, so it took a lot of time and patience. And once we arrived at that point in therapy, when he sort of was able to open up and trust us, and then he was moved away because of safety reasons.* [We] *understand a decision was taken, obviously, regarding his safety. So, he was moved to a different county, so that was difficult because we felt this disruption in the therapeutic process*" (Practitioner #3).

Several parents or carers raised the lack of community spaces that could help keep their young people safe and away from the risk posed by gang associates in the community:

> *"[If] there'd been a permanent place where he could just go on a [...] daily basis, it would have been a lot better. But, unfortunately, obviously, ASSIST don't have the funding to do that. It's a mobile unit that goes around here, there and everywhere. It would be nice if they had a permanent base where the children could say, 'Oh, look, I'm feeling this; can you take me to such-and-such?'"* (Parent/carer #1).

Regarding schooling, parents or carers also raised difficulties faced in accessing special educational needs support for their young people.

> "[The] *whole school scenario was a nightmare. That was a massive pressure on us because you don't stop fighting for your child, and I think that can be very exhausting. And I think once you keep getting your son punished every day for his learning disability, it's quite shocking and emotionally draining when you're trying to sort out another problem, as well as the learning problem. I think we've all done very well, considering we had such major things happen in the year*" (Parent/carer #3).

> "[There are] *no special schools available for him, so he's getting home-schooled at home; he's not going out at all. So, he's quite restricted at the moment, but he knows he's got that safety net of GYM [...] He's not invested in home-schooling, and they did say that they were going to bring a tutor out to give him one-on-one, and we've still not saw that. So, it's me kind of fighting for that help. It's me that got a social worker involved also, but I just feel kind of we're not getting the support that we should*" (Parent/carer #4).

For these parents or carers, lack of support heightened anxieties that young people will regress, despite the observed benefits of the programme:

> "[We've] *heard from various SEN schools that the government have cut funding, so there are limited places, limited staff, which is a real shame. I think they really need to make massive investments, and then there won't be as much crime on the street*" (Parent/carer #3).

> "[I] *just feel my son is getting failed [...] And one hour a week education, it's just not good enough. Not when he's behind anyway, and this is the risk of children like my son, of going into gangs. [...] And he's saying about giving up and stuff, but I think with the GYM's help and support, it's kind of propped him up. Without that, I don't know probably where he'd be mentally*" (Parent/carer #4).

Evaluation feasibility

The pilot evaluation allows us to draw conclusions about each of the key aims, albeit with some caution around the completeness of data recording.

Aims 1 and 2: **The direction and magnitude of change in the main outcomes and the potential effect size**

Where data have been recorded, the families report a significant improvement for the child across measures. The reported effect sizes are large and indicate a robust response within the confines of a before-after intervention evaluation. Although the rate of improvement slows, change is sustained across the time of the evaluation. It should be noted that no sensitivity analyses could be conducted, given the large amount

of missing data. The COVID-19 pandemic was a significant factor in preventing completion of outcome measures during the pilot period. However, it remains possible that families that have not provided data at follow-up were not responding as well to the programme as those families that did provide data. The outcomes, therefore, need to be treated with caution.

Aim 3: The referral and screening process

Of the 118 cases referred to ASSIST, 44 were not accepted into the service, and 74 young people were enrolled in the programme. For the majority of the referred young people, the child was 12 years old, predominantly male (90%) and white (66%) or mixed race (21%). Most referrals came from police and schools. For some young people, the time from referral to engagement was short; for others, it could take longer. This was something particularly affected by lockdown periods and school closures. In general, it appears that there was very little risk of bias in the referral and screening process. On most occasions, referred young people who did not formally start the intervention were either not eligible or did not feel that they needed or wanted support.

Aim 4: Client retention and data completion

Although it was not possible to assess the number of sessions attended by young people between time points, ASSIST GYM did report how many were retained in the programme at each time point measured.[5] Therefore, client retention, as defined by the programme, remained high. The programme reported that 69 of 74 (93%) of the families were retained in the programme for 12 months. Overall, 45 families are reported as having completed the programme, 24 are recorded as 'other', and the remaining three were recorded as still on the programme, meaning that 68% of clients enrolled were recorded as remaining engaged to the end of the evaluation phase.[6]

Aim 5: Evaluation of success criteria

Using the traffic light system drawn on above, it can be concluded that two of the success criteria were met (Green), one was missed (Red), and one may be possible to meet (Amber). Specifically, we found no evidence of bias in the screening and referral processes, and retention of families in the intervention was excellent. However, data completion rates were disappointing, meaning that we cannot say that there were sufficiently robust, unbiased processes for data completion. These three success criteria feed into the fourth: to deliver a trial of sufficient magnitude would depend on improving data completion, on the identification of a suitable control intervention, and whether families would be willing to be randomised to control or intervention.

[5] ASSIST has indicated that it has the total number of sessions attended by young people. However, the data it provided were not suitable to determine how many sessions had been attended between data collection points.

[6] Communication from the project indicates that 20 of the young people recorded as neither completed nor withdrawn, subsequently completed the programme after the evaluation phase had finished.

Aim 6: To assess implementation process

There are three main questions to be answered in interpreting the qualitative aspects of the evaluation. These relate to implementation fidelity, service-user engagement, and programme responsiveness.

Implementation fidelity

The grantee team consistently provided mentoring and therapeutic support. Both of these were generally well received by referrers and families themselves. Initial engagement and outreach were conducted in ways intended and consistent with the logic model. The consequences of COVID-19 policies and the pandemic itself meant that modes of delivery and frequency of intervention varied. Much of the content of mentoring and therapeutic sessions would have been individually tailored. So, for those young people who were able to engage during the pandemic, the experience was as closely matched as possible to that which would have been expected. There were instances where interviewees reported that planned activities had been prevented. It was also clear that a few children were unable to engage at all via modified modes of delivery.

One way in which implementation fidelity is routinely assessed is to check whether the duration and/or 'dosage' provided matches that which is articulated in an intervention's manual or logic model. It is important to note, therefore, that GYM was offered, particularly the mentoring, for as long as needed. This includes an 'open door' to reach back for help after the conclusion of the intervention. While clearly appreciated by young people and those with parental responsibility, this means that, in this instance, inconsistent dosage/frequency of intervention can be seen as being faithful to the intervention but does pose concomitant implications for potential scaling up and/or manualisation.

Service-user engagement

ASSIST is unusual in that it runs extensive outreach activities. These provide information to potential users of the service, including young people who might directly benefit and who meet the inclusion criteria, as well as teachers and others who might refer young people to the service. The outreach encompasses literally thousands of young people by whom GYM would not be needed. As such, service-user engagement is best assessed by the retention rate from baseline engagement to completion of the programme and the qualitative findings presented above. At 93%, the retention rate was impressive, although the low rate of uploaded data from core measures should also be noted as an indicator of engagement.

Nearly all interviewees were very positive about engagement of the children and young people. When young people agreed, information could be shared by mentors with parents. Although some parents indicated that they would like to have known more about what was going on in mentoring sessions, others reported that the mentor felt like part of their family, someone they could rely on and whose judgment they trusted. The extended mentoring was seen to provide additional reassurance, and the ongoing access to support, potentially at any time of the day or night, can be seen as a positive part of the families' experiences of the intervention.

Programme responsiveness

Practitioners, young people, and adults with parental responsibility provided plentiful examples of the responsiveness of therapists and mentors. Referrers might have appreciated more streamlined processes of reporting back about case progress, and there were some challenges around the boundaries of young people's confidentiality and information sharing. It seems to have been clear when safeguarding processes

needed to be invoked. Yet, it may have been frustrating to other people working with the families when information had not been shared with them that they felt would have been useful. This is not unique to this particular intervention and is not necessarily problematic. Protecting young people's confidentiality could be viewed as a demonstration of the practical difficulties in building and maintaining young people's trust. Finding a way to balance these tensions is potentially a way of sustaining credibility with all parties.

Another area where quantitative assessment was difficult was in the recording of data from the core measures. Although practitioners were somewhat positive about the measures, the data completion rate would need to improve for a randomised trial. In this instance, responsiveness of the young people and those with parental responsibility may be more challenging. A third area that was difficult to measure quantitatively was one in which the intervention team was extremely responsive. This is the setting of goals for young people. As can be seen in the logic model, GYM viewed helping some of these young people to be able to articulate their goals and aspirations as a valid early outcome, distinct from realising those goals. The challenge, from an evaluation perspective, is that it is difficult, objectively, to measure the setting of goals as initial outcomes. From a therapeutic perspective, it became clear that the attainment of goals is less important than the ongoing progress towards them. From the implementation process interviews, it is clear that setting and use of goals were recognised by family and professional interviewers as helpful.

The GYM team was under no illusion about the difficulties faced by the families and young people themselves in relation to COVID-19. They were realistic about the challenges faced by schools although sometimes frustrated when schools appeared overwhelmed to the extent that they were unable to engage at all with the intervention. Ways of working, means of working, and times of working were all reported to be extremely flexible. Indeed, the word 'flexible' came up in several interviews and can be used as a proxy for responsiveness. As noted in the findings, such flexibility may need to have some parameters built around it in order to continue to keep both staff and young people secure, but overall, there is little doubt about the responsiveness of the GYM team in implementing the intervention.

Evidence of promise

Having addressed the research questions via the assessment of aims, this section will consider the implications of the findings to the logic model (Figure 1 above).

ASSIST intended that GYM had multiple inputs, including specialised trauma therapy and intensive mentoring, that built on initial engagement, including sports, community outreach, workshops, and presentations. All of these happened, although the role of social media grew in importance during the pandemic. Also, it became clear from the interviews that families particularly appreciated the intensive mentoring.

The immediate outputs that had been identified within the model were also largely consistent with what was found during the evaluation. Mentors established positive relationships with young people and often with their wider families. They were seen as positive role models. We have no indication that trauma-informed therapy was not delivered, but there is little indication of its impact and what it meant in practice. It was also difficult to judge what was or was not 'appropriate' about the extent and nature of families' and carers' involvement in the process. Generally, they were very positive. Yet, in some cases, adults with parental responsibility indicated that they would have liked to have known more. It could be argued that even if adults would have liked to have understood more, this may not have been deemed appropriate for

a specific young person. However, there is no evidence with which to test this aspect of the findings. In a future study, it would be useful to unpick this further. Similarly, the working relationships with schools and referring agencies seemed to be very positive, but there were instances where information sharing was queried and some cases where schools simply did not engage. This may have been more to do with the school's operating circumstances than with GYM staff's attempts at engagement, but again, there is no suitable data; this, too, could be followed up.

Where data had been collated, short-term outcomes were met. The data completion rates already commented on also pertain here. Goals were set, and there was limited evidence of positive futures being envisaged, but they could not be systematically assessed. Lastly, assessment of the mid- to long-term outcomes was beyond the scope of this evaluation.

Overall, the evaluators are cautiously optimistic that the logic model was a fair reflection of what was found in the evaluation and that significant modification would not be necessary prior to a randomised trial. It might, however, be worth restating that the inclusion criteria were broad. Similarly, the duration and dosage of mentoring were flexible. If a randomised controlled trial was to be undertaken, then some tightening of parameters would be necessary.

Readiness for trial

As discussed in the findings and evidence of feasibility sections, it may be possible to conduct a full trial, but the intervention is not quite ready. In particular, it would be important to be sure of the following:

1. Whether the current programme would be able to increase capacity, or if other sites could be identified
2. If sufficient evidence could be gathered to indicate that data completion can be improved
3. Whether a suitable control intervention could be identified that is not subject to too much heterogeneity
4. Whether families would be willing to be randomly allocated to intervention or control arms of a trial.

Conclusion

Table 22: Summary of pilot study findings

Research question	Finding
Core outcomes over time	Reported changes over time tended to be large, in the desired directions and statistically significant. However, the large proportion of missing data makes interpretation difficult. The COVID-19 pandemic was a significant disruptive factor in preventing completion of outcome measures during the pilot period.
Effect size	For most of the core measures, reported effect sizes indicate evidence of promise for the intervention. However, CRIES-8 and SCORE 15 were not implemented consistently, and there was considerable variance in the ESYTC scores (though the overall downward trend was statistically significant here, too).
Referral and screening	Referral and screening processes seemed to be working appropriately, and there was little risk of bias.
Retention and data completion	Retention with the programme was very high at 93%, although it should be noted that this does not match the proportions of recorded data, which was from less than half the cohort at six months and down to just under a third of the baseline cases by 12 months. As such, we conclude that family retention was high, but data collation was compromised, both by COVID-19 and therapeutic decisions made about pursuing data completion.
Potential to move to a randomised trial	There remains the potential to complete an appropriately powered trial, but several issues would need to be addressed to recommend progression to a full trial: i. Can sufficient evidence be gathered to indicate that data completion can be improved? ii. Can a suitable control intervention be identified that is not subject to too much heterogeneity? iii. Can evidence be gathered to indicate that families would be willing to be randomly allocated to control or intervention? If these issues can be addressed, it is likely that a trial of sufficient magnitude can be delivered.
Fidelity of intervention	Despite changes that had to be made for COVID-19, ASSIST GYM was broadly implemented as initially intended and in close alignment with the logic model. The degree of personalisation of the approach, particularly the open-ended mentoring, may make 'dosage' comparisons difficult to assess in future research.
Service-user engagement	The grantee's files show a very high retention rate, and the implementation process interviews indicate that service-user engagement was commendable and sustained. However, it was clearly difficult to gain service-user engagement in completing the core measures.
Intervention responsiveness	The flexibility and responsiveness of the mentors, in particular, were noted by interviewees from each key group (children, adults with parental responsibility, referrers, and other professionals). There were a few concerns raised, such as parents who would have liked to know more about what happened in mentoring sessions or staff from other agencies who would have appreciated additional information. However, the responsiveness was noted multiple times, and there was shared understanding by all that if a child or young person's safety was in question, information would always be shared promptly and completely.

Evaluator judgement of intervention and evaluation feasibility

ASSIST GYM is a well-regarded intervention, appreciated by young people, adults with parental responsibility, referrers, and those who work within the team. The staff, particularly the mentors, are available to families as and when needed, for almost as long as necessary. There are some challenges for wider roll-out, sustainability, and a potential future trial, but there is promise here that the intervention can make a positive, sustained impact on young people's lives. With the caveats already identified, it is possible that both intervention and further evaluation are feasible.

Interpretation

The stated mission is to work from trauma to recovery. This ambitious claim is impossible to assess within the evaluation framework. Findings indicate changes in positive directions on core measures and strong appreciation of the intervention. Of themselves, these findings are not sufficient to make a judgement on recovery, although they do indicate progress. The notion of recovery is not part of the logic model, and evaluators suggest that the mission be modulated somewhat to a more testable statement.

As noted in the background section of this report, ASSIST follows NICE guidance in providing trauma-informed intervention. Rather than providing services to treat one or more particular aspects of trauma, a TIA seeks to be engaging and accessible and to avoid worsening the trauma by not acting in ways that are appropriate (University of Buffalo 2019). The implementation process findings indicate that families find the GYM staff to be approachable, accessible, and trustworthy. Young people see them positively and respond favourably to the intervention. This would be much harder and less likely to succeed if the intervention itself were triggering or potentially retraumatising. So, although there is not a robust evidence base on trauma-informed practice to ground the findings, it seems fair to conclude that the intentions of acting appropriately and accessibly are met.

This is particularly clear when it comes to the role of the mentors. Mentors in this programme are consistent; work hard to develop and sustain good relationships with young people and their families; are available for frequent, meaningful contact; and thus seem to be acting in ways most likely to succeed, especially regarding the depth of emotional support they provide (Tolan 2013).

When considering the transferability and generalisability of the findings presented in this report, there are some limitations as well as future implications to be considered. The first limitation is the difference between intervention retention rates and data completion rates needed for evaluation. The latter would have to be improved before a randomised trial could be comfortably started. Each core measure was used to a different extent, and it would be worth considering each measure separately prior to a wider rollout. For example, it would be hard to argue that the IES-R should be dropped, given that the literature indicates trans-generational trauma is likely, but no parents completed this measure. This may have been because the intervention is so focused on the children and young people, and it may therefore be satisfactory to drop that measure. Similarly, school ratings on the SDQ were difficult to obtain. It would be worth considering their likely utility moving forward and whether they add much beyond the ratings of parents/carers and young people themselves. In considering the SDQ, it may be worth noting the practitioners' positive views of its adoption, particularly given that there have been concerns raised in the literature regarding its readability and accessibility for children and young people (Black, Mansfield and Panayiotou 2020). Another potential limitation should be simpler for the intervention to address prior to a

trial. That is, regarding data recording and reporting on the number of potential sessions that could have been and were attended, whether for direct therapy or wraparound.

Another potential limitation relates to the participant implementation process assessment. As this element is qualitative research, generalisability is not really a relevant criterion. The similarity and consistency across many of the themes are reassuring, but it should be noted that the views expressed by those who participated may not be consistent with those that would be found from a different set of participants had they been recruited. This is particularly pertinent given the lockdowns and other responses to COVID-19 that may become a decreasing part of intervention reality.

Although the findings indicate no significant causes of bias in recruitment or retention to the intervention, some caution needs to be exercised regarding the data completion rates. It is possible that those who did not complete the measures differed in some way that was not accounted for in this design. Lastly, this evaluation did not consider the nature of what a control intervention might look like. For most of these families, there is no 'treatment as usual'. It would therefore be necessary to consider what a control intervention might look like and who would provide it.

Future research and publications

Allowing for the caveats above, evaluators believe that a randomised trial may be possible, broadly adopting similar principles to this design. Other suggestions for future work might include delving deeper into judgements made around information sharing with families and working relationships with schools. Additionally, secondary analyses or separate publications of the findings across all four grantees evaluated by this team may provide some additional insight into theory and practice.

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Appendices

Appendix A: Ethics Approvals

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Dr Tim McSweeney

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.

DATE 01/04/2020

Protocol number: **LMS/SF/UH/04101**

Title of study: A feasibility study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Prof Brian Littlechild (CI) Dr David Wellsted (CI)
Ms Helen Munro-Wild (CI)
Prof Joanna Adler (PI) from LMS.

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid: From: 01/04/2020 To: 30/10/2020

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Dr Tim McSweeney

FROM Dr Rosemary Godbold, Health, Science, Engineering & Technology ECDA Vice Chair

DATE 30/09/2021

Protocol number: **LMS/SF/UH/04697**

Title of study: A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid: From: 30/09/2021 To: 31/03/2022

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Tim McSweeney

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair

DATE 16/03/2022

Protocol number: **aLMS/SF/UH/04697(1)**

Title of study: A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Joanna Adler David Wellsted Brian Littlechild

Modification: detailed in EC2. (Extension to November, 2022).

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix B: Feasibility Interview Materials

Information Provided to Potential Interviewees

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC6: PARTICIPANT INFORMATION SHEETS

1 **Title of study**

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: ASSIST

Information for a Child/Young Person Potential Interviewee

SOME INFORMATION ABOUT THE RESEARCH

1 We'd like to ask you if you'd be interested in taking part in some research. But before you decide whether to do so, it is important that you understand what the research is about and what you are being asked to so. Please take the time to read the following information carefully and discuss it with others if you'd like.

Thank you for reading this.

2 **What's the research about?**

One of the projects you've been seeing –ASSIST - is working to prevent young people aged between 10 and 14 from getting caught up in crime and violence by offering them (and sometimes their parents) the best possible support, as early as possible. Researchers from the University of Hertfordshire (UH) are talking to people who are getting this support to see if they think it's helpful.

3 **Do I have to take part?**

No. It is completely up to you whether to take part or not.

4 **How long will my part in the study take?**

One of the researchers will ask you some questions about the project and the support they've been giving you. This shouldn't take more than 30 minutes.

5 **What will happen to me if I take part?**

A UH researcher will arrange with an adult who looks after you, or a member of staff at the project, a good date, time and place for you to meet and talk about the support you've been getting. With your permission, the researcher may want to record your chat with a small voice recorder. This will make things easier and quicker as they won't have to make notes of what you're saying. If you'd rather they didn't record it that's fine – please just tell them when you meet. After the UH researcher has asked you all their questions, they will give you a £10 Love2shop voucher as a 'thank-you' for taking part in the research. You'll have to sign a piece of paper just to say you've received this.

6 **Will anyone get to see or hear what I say?**

We won't record or use your name in the research. All the information about you will be held safely and securely by UH. What you tell us is confidential (so no-one else will see or know what you've said).

7 **What happens with the information I give you?**

We will use what you and others tell us to say whether the support that the project offers is useful and helpful to young people. We can also make suggestions about how things can be improved so that young people get more or better help. But nobody will be told what you have said about the project.

8 **Can anything we talk about be shared with others?**

If you tell the researcher from UH that you or another person is at risk in some way then by law we would have to share that information with the project, and possibly other people too, in order to protect you or the other person.

9 **Who has reviewed this study?**

This study has been reviewed and approved by the UH, Science, Engineering and Technology Ethics Committee.

The UH protocol number is **LMS/SF/UH/04101**

10 **Who can I contact if I have any questions?**

If you have any questions about the research then you can telephone or email one of the UH researchers: either Brian (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim (01707284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this research, then please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Thank you very much for reading this information and thinking about taking part in this study.

Information for a Parent/Carer/Guardian Potential Interviewee

1 **Title of study**

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: ASSIST

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand what the research is about and what you are being asked to so. Please take the time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

3 **What is the purpose of this study?**

The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. This independent study is being conducted by a team of researchers from the University of Hertfordshire (UH) who are evaluating the work of four family-focused interventions: ASSIST, Family Support, Brandon Centre and RISE Mutual. The key questions for the feasibility study are to better understand: the factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; and, service users' experiences and views of the intervention.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete the interview. You are free to withdraw at any stage (up to 17th July 2020) without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not adversely affect you and/or your child in any way.

5 **How long will my part in the study take?**

If you decide to take part in this research, then you will be invited to talk with an independent researcher from UH to discuss your views and experiences of the support that you and/or your child has received. This may take approximately 40-50 minutes.

6 **What will happen to me if I take part?**

A member of the UH research team will arrange a meeting with you at a mutually convenient date, time and location. You will then be asked to complete a consent form and tell the researcher about your views and experiences of ASSIST.

The conversation with the researcher from UH is confidential. With your permission, what you discuss may be audio-recorded for the purposes of transcription and data analysis, but the recordings will be destroyed at the end of the study (i.e. by 30th October 2020). After the UH researcher has asked you all their questions, they will give you a £10 Love2shop voucher as a 'thank-you' for taking part in the research. You'll have to sign a piece of paper just to say you've received this.

7 **How will my taking part in this study be kept confidential?**

Your confidentiality will be respected at all times. We will use a code rather than your name. Your anonymised data may be kept for up to five years after which it will be securely destroyed by UH. Consent forms will be stored in a lockable cabinet separately to other study data and will be

destroyed upon completion of the study (i.e. by 30th October 2020). All electronic files will be stored on UH secure servers which are firewalled and password protected.

8 **What will happen to the data collected within this study?**

We will use the data collected to assess how effective the YEF-funded projects are. UH is responsible for looking after your information and using it properly. No personal data (e.g. names) will be shared and all data will be anonymised. The results of the study will be used to inform future planning for the work of YEF. Any research reports will not identify you individually.

9 **Who has reviewed this study?**

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/SF/UH/04101**

10 **Factors that might put others at risk**

Please note that if, during the study, any unlawful activity becomes apparent that might or has put you or others at risk, UH may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

11 **Who can I contact if I have any questions?**

If you would like further information, or would like to discuss any details personally, please get in touch with us, in writing, by phone or by email: either Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk)Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Thank you very much for reading this information and giving consideration to taking part in this study.

Information for a Practitioner/Stakeholder Potential Interviewee

1 **Title of study**

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: ASSIST

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish.

Thank you for reading this.

3 **What is the purpose of this study?**

The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. This independent study is being conducted by a team of researchers from the University of Hertfordshire (UH) who are evaluating the work of four family-focused interventions: ASSIST, Family Support, Brandon Centre and RISE Mutual. The key questions for the feasibility study are to better understand: the factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; and, service users' experiences and views of the intervention.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage (up to 17th July 2020) without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not adversely affect you in any way. If you have any concerns about taking part, please discuss this with your manager and/or supervisor.

5 **How long will my part in the study take?**

If you decide to take part in this study, then you will be invited to speak with a researcher from UH to answer some informal questions about your views and experiences, and this will take approximately 40-50 minutes.

6 **What will happen to me if I take part?**

A member of the UH research team will arrange a meeting with you at a mutually convenient date, time and location. You will then be asked to complete a consent form and participate in an interview (or possibly a focus group) in order to answer a set of questions about the work of the YEF-funded project.

The interviews/focus groups will be conducted by an independent researcher from UH.

The researcher will ask you about your views on the work you and others are doing with children and/or families receiving YEF-funded support. We are interested in your opinions and there are no right or wrong answers. With your permission, the interview will be audio-recorded for the purposes of transcription and data analysis, but the recordings will be destroyed at the end of the study (i.e. by 30th October 2020).

7 **How will my taking part in this study be kept confidential?**

Participant confidentiality will be respected. We will use an anonymity code rather than your name and your organisation will not be identified. Anonymised data will be kept for up to five years after which it will be securely destroyed. Consent forms will be stored in a lockable cabinet separately to other study data and will be destroyed upon completion of the study (i.e. by 30th October 2020). Audio files will only be stored on computers belonging to UH and will only be available for the purposes of data analysis. All electronic files will be stored on UH secure servers which are firewalled and password protected.

8 **What will happen to the data collected within this study?**

We will use the data collected to assess the feasibility of the YEF-funded projects. UH is the data controller for the study. This means we are responsible for looking after your information and using it properly. No personal data (e.g. names) or details of your organisation will be shared and all data will be anonymised. The results of the study will be used to inform future planning for the work of YEF. Any research reports will not identify you individually.

The data collected as part of the study will be stored electronically, in a password-protected environment, for up to five years, after which time it will be destroyed under secure conditions. All such data will be anonymised prior to storage. Any data collected in hard copy by UH (e.g. copies of consent forms) will be stored in a locked cupboard until 30th October 2020, after which time they will be shredded.

9 **Who has reviewed this study?**

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/SF/UH/04101**

10 **Factors that might put others at risk**

Please note that if, during the study, any unlawful activity becomes apparent that might or had put others at risk, UH may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

11 **Who can I contact if I have any questions?**

If you would like further information or would like to discuss any details personally, please get in touch with us, in writing, by phone or by email: either Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Parent/Carer/Guardian Consent for Family Participation: Feasibility Interview Phase

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project

ASSIST

(UH Protocol number **LMS/SF/UH/04101**)

Name of project evaluation leads: *Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).*

Please initial b

1. I confirm that I have read the information sheet dated **{insert date} ({insert version number}**) for the interview phase of the above study. I have had the opportunity to consider the information about the interview, ask questions and have had these answered satisfactorily. ☐
2. I understand that my, and my child's, participation in the interview is voluntary and we are free to withdraw or change our mind at any time without giving any reason, without our support or legal rights being affected. ☐
3. I understand that the information collected about me and my child will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
4. I agree to having the conversation with me and my child audio-recorded. ☐
5. I confirm that I am happy for me, and my child, to take part in the interview. ☐

Name of Parent/Carer/Guardian	Date	Signature
Name of child	Your relationship to the child	
Name of Person taking consent	Date	Signature

2 copies – 1 to the parent/carer and 1 to University of Hertfordshire

Consent form: Stakeholders/Practitioners

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project ASSIST

(UH Protocol number **LMS/SF/UH/04101**)

1 I confirm that I have been given a Participant Information Sheet giving details of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to me. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it. I understand that this study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that a voice recording will take place and I have been informed of how this recording will be used.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

5 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Signature of participant……...…Date……

Signature of (principal) investigator……Date……

Name of (principal) investigator *[BRIAN LITTLECHILD / TIM MCSWEENEY]*

……

Topic Guide for use with Families

- How did you first hear about the project?
- What did you find valuable/attractive in what you were told about the programme at the start of it?
- What did you see as the main challenges you and/or your family had when you were first referred to the programme?
- What hopes had you about how the programme and how it might help you/your family when you were accepted?
- What were your concerns, if any, about engaging with the programme?
- What help/support had you tried before, if anything, and had any of these things been successful in any ways at all? Has your involvement in this programme been any different in terms of positive changes for you/your family?
- What has worked well while you have been on the programme - for you? For your family?
- What have you found most difficult or unhelpful on the programme so far?
- How far do you think things have changed in a positive way as a result of your involvement with the programme (so far)?
- What have you found most challenging in terms of keeping up with the demands of the programme, and in making changes whilst on the programme (so far)?
- What other factors do you think have affected for you/your family - whether things have got better (or not) since you started the programme? For example, other help and support you have received, what is happening at school, with friends/acquaintances etc.?
- What has changed least in relation to 1) the challenges you/or family were facing when you started the programme 2) in relation to what you had hoped for as a result of at taking part in the programme?
- Have other members of your family experienced any changes from your involvement in programme so far? If we were to ask others involved with yourself and your family, such as school staff etc., what do you think they might say as to whether there have been improvements in the challenges you are experiencing?
- Have you looked at your/your family's progress with the challenges you were experiencing when you came onto the programme with your worker, and if so how did you do this, and in what ways did you think there had been improvements (or not)?
- If we were to ask your worker, what do you think they would say 1) the main things that have been positive in terms of change for you/or family, 2) things maybe still need to be worked on rather more?

Topic Guide for use with Stakeholders/Practitioners

- Can you please describe the main elements of the programme which you are carrying out with children and/or parents (if applicable)? Please describe the main purpose of it, main methods and skills utilised, and the aims of it?

- What you think the main challenges have been in relation to engaging with the parents (if applicable) and young people in terms of meeting the aims of the programme/interventions so far?

- If we were to ask the children/parents/carers in the families what they had hoped for at the beginning programme and whether this was being achieved or not, what do you think they might say?

- What do you think are the main strategies/elements that you have employed in terms of how you have engaged with the children and parents/carers in the families (if applicable)?

- How have you reviewed progress with them, and the outcomes so far of your interventions?

- As you know, we are collating statistics in relation to referrals, acceptance, progression rates etc. We would like to explore with you your views on the families referred so far, the appropriateness of those referrals/acceptances, and any issues about engagement. Please tell us about your general views on these areas.

- If we were to ask the children/parents/carers in the families their views on how well they have engaged with the programme, and the value of it, what do you think they might say?

- If we were to ask them what the main areas of positive change had been, and why, what you think they might say?

- In terms of the children and/or families accepted on to the programme, to what extent do you think you have managed to keep to the main elements/focus of it, and how much have you had to adapt what you do in relation to the ongoing work in light of reviewing the effectiveness of it?

Thank you….

Debriefing

If you have been affected by any of the issues we have discussed during the course of the research then please consider approaching a member of the project team for advice and support. Alternatively, the following sources of advice, support and information may be useful.

1. Childline

Call free on 0800 1111 or get in touch online at https://www.childline.org.uk/get-support/

2. Samaritans

The Samaritans are available 24 hours a day, 365 days a year to support you with whatever you're going through.

https://www.samaritans.org

Tel: 116 123

Email: jo@samaritans.org

3. Ask to speak to one of your school teachers

4. Contact your local GP or NHS Direct

NHS 111 can help if you have an urgent medical problem and you're not sure what to do.

Call 111 on your phone or go to https://111.nhs.uk/

5. Emergency services

In an emergency, contact the emergency services.

Tel: 999

University of Hertfordshire School of Life and Medical Sciences Risk Assessment Form

Ref No:	
Date:	
Review Date:	

For assistance in completing this form, please see the Guidance Notes at the end

ACTIVITY INFORMATION	
Name of Assessor/ Contact details	Name: Dr Tim McSweeney Email address: t.mcsweeney@herts.ac.uk Ext no: 5284
Title of Activity	A feasibility study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.
Location of Activity	It is envisaged that fieldwork for the study will be undertaken either on the premises of the service being evaluated (ASSIST in Northamptonshire, Family Support, Brandon Centre and RISE Mutual, all of whom deliver service in London), or remotely over the phone or online (e.g. using Zoom software). Where necessary and appropriate, some interviews with parents and carers may be undertaken in public spaces (e.g. cafes).
Description of Activity Please attach a copy of the protocol, procedure, SOP etc applicable.	The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. The feasibility study will involve a team from the University of Hertfordshire (UH) evaluating the work of four family-focused interventions (ASSIST, Family Support, Brandon Centre, RISE Mutual). The key questions for the feasibility study are to better understand: the factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; and, service users' experiences and views of the intervention.
Personnel Involved	Dr Tim McSweeney (CI), Prof Brian Littlechild (CI), Dr David Wellsted (CI), Ms Helen Munro-Wild (CI) and Prof Joanna Adler (PI) from LMS.

TYPES OF HAZARD LIKELY TO BE ENCOUNTERED		
☐ Animal Allergens ☐ Biological Agents (see COSHH) ☐ Chemical Compounds (see CoSHH) ☐ Compressed/liquefied gases ☑ Computers ☐ Electricity ☐ Falling Objects ☐ Farm Machinery ☐ Fire ☐ Glassware Handling	☐ Hand Tools ☐ Ionising Radiation ☐ Office Equipment ☐ Laboratory Equipment ☐ Ladders ☐ Manual Handling ☐ Non-ionising Radiation ☐ Hot or cold extremes ☐ Repetitive Handling ☐ Severe Weather	☐ Sharps ☐ Slips/trips/falls ☑ Stress ☐ Travel ☐ Vacuum systems ☐ Pressure systems ☐ Vehicles ☑ Aggressive response, physical or verbal ☐ Workshop Machinery
The above is not an exhaustive list – all other hazards should be listed here. Vulnerable children (at risk of offending) and their parents/carers. Some respondents may experience distress, feel vulnerable having shared their personal experiences, and be anxious about the use of their accounts to inform the research.		

HAZARD ASSESSMENT						
Severity of Consequences	Score	Risk Classification				
No or minor injury/ health disorder Minor Damage or Loss Insignificant Environmental Impact Group 1 Biological agents	1	Trivial (1)	Trivial (2)	Trivial (3)	Trivial (4)	Tolerable (5)
Injury or Health Disorder – resulting in absence up to 3 days Moderate Damage or Loss Moderate Environmental Impact Group 2 Biological agents	2	Trivial (2)	Trivial (4)	Tolerable (6)	Tolerable (8)	Moderate (10)
Injury or Health Disorder – resulting in absence over 3 days Substantial Damage or Loss Serious Environmental Impact Group 3 Biological agents	3	Trivial (3)	Tolerable (6)	Moderate (9)	Moderate (12)	Substantial (15)
Long Term Injury or Sickness – resulting in permanent incapacity Extensive Damage or Loss Major Long Term Environmental Impact	4	Trivial (4)	Tolerable (8)	Moderate (12)	Substantial (16)	Intolerable (20)
Death Serious Structural Damage Environmental Catastrophe Group 4 Biological agents	5	Tolerable (5)	Moderate (10)	Substantial (15)	Intolerable (20)	Intolerable (25)
Note on Risk Classification: 1-4 Trivial 5-7 Tolerable 8-12 Moderate 13-16 Substantial >20 Intolerable	→ Likelihood	1 Almost Impossible	2 Unlikely – possible exposure every 1-3 years	3 Harm is possible	4 Harm is likely to occur	5 Harm will occur or is very likely to occur.

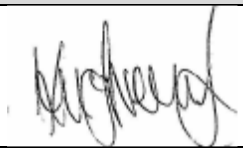
ASSESSMENT OF RISK CLASSIFICATION			
Hazard	Likelihood Score	Severity Score	Risk Classification
Stress Emotional discomfort or distress	3 3	1 1	3 (Trivial) 3 (Trivial)

Aggressive response, physical or verbal	3	1	3 (Trivial)

EFFECT OF RISK CLASSIFICATION	
Risk Classification	Action
Trivial	No further action required. Activity can begin.
Tolerable	No additional controls required. Current controls must be maintained and monitored.
Moderate	Reduce risks if cost effective. Implement new controls over an agreed period.
Substantial	Activity cannot begin without major risk reduction.
Intolerable	Activity must not begin.

RISK CONTROL MEASURES
Are the local code of practice and/or local rules adequate to control the risks identified? Yes Please list. Please list all additional measures required.
Local Code of Practice and Local Rules applicable: All LMS health and safety rules will be followed including 'LMS Health and Safety Codes of Practice', the 'BPS Code of Ethics & Conduct (2009)' and 'BPS Code of Human Research Ethics (2014)'. Additional Measures: All respondents will be debriefed and offered referrals and contact details for additional support (e.g. a range of suitable charities, ensuring people are not directed again to services in which they have had negative experiences). The scope for any harms, hazards and risks to the safety of the investigators are considered negligible as it is envisaged that all data will be collected on service premises, online (via video conferencing) or over the phone. As PI, Professor Joanna Adler is available to debrief any members of the research team who experience distress as a consequence of the data gathered during the course of the research (e.g. through qualitative interviews).

HEALTH SURVEILLANCE ISSUES	
Persons at Special Risk	Children at risk of involvement in crime and violence, their parents, carers or guardians, and professionals working with them.
Health Surveillance Measures (including symptoms and signs of exposure)	It is possible that some respondents may experience distress, or become aggressive (verbally) as a consequence of recalling their experiences of crime and/or violence.
Exclusions	Respondents must be consenting service users of the YEF funded project or a professional stakeholder linked to the delivery of these interventions.

	SIGNATURES			
	Staff/PhD student/MSc student/Undergraduate	Name (Print)	Signature	Date
Assessor	Staff	Tim McSweeney		26/02/2020
Supervisor (if Assessor is a student)	N/A			
Local Health and Safety Advisor / Laboratory Manager	Health and Safety Lead (Psychology)Staff	John Bain		27/02/2020

GUIDANCE NOTES.

This Risk Assessment is the legally required written record of the Risk Assessment for an activity. It must include all known risks and hazards involved in the activity, to the best of the assessor's knowledge. Both the Risk And CoSHH Assessments must be signed off by signatories prior to work starting. No changes may be made to this document without being countersigned by all signatories.

The purpose of this Risk Assessment is to identify risks arising from specific activities and substances and put into place safe working practices to minimise these risks.

Copies of this Risk Assessment must be available at all times during the period of the activity.

For clarity and help in filling this form in, please read the following notes:

ACTIVITY INFORMATION

Name of Assessor - contact details must be included here.

Title of Activity – this should be brief but specific to the details here.

Location of Activity – any rooms, buildings or venues where this activity will be carried out must be included.

Description of Activity – a brief description of the activity proposed. This MUST include any materials used, classes of substances used (e.g. micro-organisms) equipment used and analytical and preparatory processes and techniques if they are being used. Do not forget to include by-products of any activity.

Personnel Involved – anyone who will be present in the area during the activity. This should be groups of people where possible, e.g. undergraduate students.

TYPES OF HAZARD LIKELY TO BE ENCOUNTERED

This is a list of the more common hazards likely to be encountered within Life and Medical Sciences. Tick those that will be encountered during the proposed activity. Any additional hazards must also be included here.

HAZARD ASSESSMENT

This table is the heart of this assessment. By looking at the severity of the consequence of being exposed to a hazard and measuring that against how likely this may happen you can calculate how much risk is involved.

Severity x likelihood = risk.

If the proposed activity has a high risk (i.e. a high number) then control measures will need to be put in place.

RISK CONTROL MEASURES – Refer and list the local codes of practice, guidelines and local rules of the area where the activity will be carried out for *minimum* safe practices.

Additional Measures– this details the measures that can reduce the risk. For example – using volatile solvents in a fume hood, or arranging for interviews to be conducted in a public place.

ASSESSMENT of RISK CLASSIFICATION

Hazard – this is a list of all hazards encountered in the activity as identified earlier.

Likelihood Score – this is a measure of how likely it is that a hazard will occur. Identified from the Hazard Assessment table

Severity Score – this is a measure of how severe exposure to any given hazard can be. Identified from the Hazard Assessment table. Use the highest score for each hazard.

Risk Classification – this is the result from the Hazard Assessment table and will be one of the following words – trivial, tolerable, moderate, substantial or intolerable.

EFFECT OF RISK CLASSIFICATION – this table indicates whether the proposed activity can begin and if other controls must be put into place.

HEALTH SURVEILLANCE ISSUES – this looks at how hazards can specifically affect health of people coming in contact with the proposed activity.

Persons at Special Risk – this must include anyone who has a special health issue with hazards involved – e.g. pregnant women, specific allergic reactions, asthmatics, immune-suppressed individuals etc.

Health Surveillance Measures – this must include symptoms of exposure to hazards involved. For example, chemicals and drugs can cause dizziness and drowsiness. Outside working can involve extremes of temperature i.e. summer and winter working.

Exclusions – this should include a list of anyone who should not take part in this activity, e.g. pregnant women, or anyone with a pacemaker.

SIGNATURES – all required signatures must be completed before work can commence.

Assessor – this is the person who has filled in the Risk Assessment.

Supervisor – an academic member of staff with responsibility for the assessor if the assessor is a student.

Local health and safety advisor – a named person who is familiar with the area specified for the activity to take place. A list of current local health and safety advisors for each Department is given below (removed for publication of Appendices):

DEFINITION OF TERMS

HAZARD - a potential source of harm

HARM – personal injury or damage to property

RISK – a combination of the likelihood of harm arising from a hazard and the severity of that harm.

RISK ASSESSMENT – identification of hazards and a classification of the risk they produce.

RISK CONTROL – physical control and/or the safe system of work required to reduce the risk to acceptable levels.

Appendix C: Feasibility Data Audit

ASSIST Trauma Care

Note that the data audit was conducted to check systems and processes for data uploading. The numbers here are of those cases uploaded by that point of audit, not all the cases subsequently uploaded relating to the full feasibility phase.

ASSIST have provided referral/screening and participant data as one datafile.

Table 1: Data Intended to be Collected at Each Timepoint

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)
GYM Number	X						
Date of referral	X						
Age							
Gender							
Ethnicity							
Family background	?						
Engagement with other progs (e.g. RISE)		?					
Referrer	X						
Therapist		X					
Risk score (0-16)*		X					
Main difficulties	X	X					
Index of Deprivation		?					
SDQ		?	X	X	X	X	X
Score 15		?	X	X	X	X	X
IES/CRIES8		?	X	X	X	X	X
ESYTC		?	X	X	X	X	X
GAD-7?		?	?				
DAS?		?	?				
PHQ-9?		?	?				
Study End Form							X

Data Collected

Screened: 51
Unsuitable: 18
Enrolled: 33
Followed up:

- *3 months: 9 out of possible 31*
- *6 months: 21 out of possible 29*
- *9 months: 3 out of possible 23*
- *12 months: 14 out of possible 19*

Table 2: Actual Data Collected at Each Timepoint

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)
GYM Number	?						
Date of referral	51 (100%)						
Age	51(100%)						
Gender	51 (100%)						
Ethnicity	51 (100%)						
Family background	MISSING						
Engagement with other progs (e.g. RISE)		MISSING					
Referrer	51 (100%)						
Therapist		MISSING					
Risk score (0-16)*		MISSING					
Main difficulties	?	MISSING					
Index of Deprivation		MISSING					
SDQ			P: 28 (84.8%) T: 5 (15.2%) C: 31 (93.9%)	P: 6 (19.4%) T: 3 (9.7%) C: 7 (22.6%)	P: 19 (65.6%) T: 3 (10.3%) C: 19 (65.6%)	P: 2 (8.7%) T: 1 (4.3%) C: 2 (8.7%)	P: 8 (42.1%) T: 7 (36.8%) C: 8 (42.1%)
Score 15			P: 0 (0%) C: 31 (93.9%)	P: 0 (0%) C: 7 (22.6%)	P: 0 (0%) C: 19 (65.6%)	P: 0 (0%) C: 2 (8.7%)	P: 0 (0%) C: 8 (42.1%)
IES			0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
CRIES8			0 (0%)	8 (25.8%)	20 (69.0%)	1 (4.3%)	8 (42.1%)
ESYTC			5 (15.2%)	3 (9.7%)	5 (17.2%)	2 (8.7%)	8 (42.1%)
GAD-7?			?				
DAS?			?				
PHQ-9?			?				
Study End Form							9 (47.4%)

Family background, engagement with other programs, therapist, risk score, main difficulties, index of deprivation not on database.
GAD-7, DAS and PHQ-9 also not included (results were sometimes added into notes).

Baseline Assessment dates:
Based on baseline assessment date, numbers with long enough follow up are:

- 3 months: 31
- 6 months: 29
- 9 months: 23
- 12 months: 19

Referral/Screening Data: 51 referred/screened

Referral Data collected:

- Age (*Date of Birth*)
    - 100% Complete
    - Screened aged 10-16 years
- Gender (*Gender*)
    - 100% complete
    - Screened: 7 female (13.7%), 44 male (86.3%)
- Ethnicity (*Ethnicity*)
    - 100% complete
    - Screened: 4 Asian (7.8%), 3 Black (5.9%), 14 Mixed (27.5%), 1 Other (2.0%) 29 White (56.9%)
- Family Background
    - Missing
- Referrer (*Where was the participant referred from?*)
    - 100% Complete, but 8 were "other"
    - 4 Parent (7.8%), 11 Police (21.6%), 24 School (47.1%), 3 Social Worker (5.9%), 1 YOS Worker (2.0%), 8 Other (15.7%)
    - Referrals from November 2019 to January 2021
    - Time from referral to enrolment ranged from same day to 175 days

Participant Data: 33 enrolled

Collected:

- Age (*Date of Birth*)
    - Enrolled aged 10-14 years
- Gender (*Gender*)
    - Enrolled: 6 female (18.2%), 27 male (81.8%)
- Ethnicity (*Ethnicity*)
    - Enrolled: 2 Asian (6.1%), 2 Black (6.1%), 11 Mixed (33.3%), 18 White (54.5%).

Baseline

- SDQ
    - 28 parent surveys complete (84.8%)
    - 5 teacher surveys compete (15.2%)
    - 31 child surveys complete (93.9%)
- Score 15
    - 0 parent surveys complete (0%)
    - 31 child surveys complete (93.9%)
- IES/CRIES8
    - None
- Edinburgh (ESYTC):
    - 5 child surveys complete (15.2%)

3 months
2 participants with date of enrolment 1st Dec 2020 onwards (i.e. too soon for 3 month follow up).

Records for 9 participants out of possible 31.

- SDQ
    - 6 parent surveys complete (19.4%)
    - 3 teacher surveys compete (9.7%)
    - 7 child surveys complete (22.6%)
- Score 15:
    - 0 parent surveys complete (0%)
    - 7 child surveys complete (22.6%)
- IES
    - None
- CRIES8
    - 8 complete (25.8%)
- Edinburgh (ESYTC):
    - 3 complete (9.7%)

6 months
4 participants with baseline assessment 1st September 2020 onwards (i.e. too soon for 6 month follow up).

Records for 21 participants out of possible 29, but 1 entry had no questionnaires completed:

- SDQ
    - 19 parent surveys complete (65.6%)
    - 3 teacher surveys compete (10.3%)
    - 19 child surveys complete (65.6%)
- Score 15:
    - 0 parent surveys complete (0%)
    - 19 child surveys complete (65.6%)
- IES
    - None
- CRIES8
    - 20 complete (69.0%)
- Edinburgh (ESYTC):
    - 5 complete (17.2%)

9 months
10 participants with baseline assessment 1st June 2020 onwards (i.e. too soon for 9 month follow up).

Records for 3 participants out of possible 23, but 1 entry had no questionnaires completed:

- SDQ
    - 2 parent surveys complete (8.7%)
    - 1 teacher surveys compete (4.3%)
    - 2 child surveys complete (8.7%)
- Score 15:
    - 0 parent surveys complete (0%)
    - 2 child surveys complete (8.7%)
- IES
    - None
- CRIES8
    - 1 complete (4.3%)
- Edinburgh (ESYTC):
    - 2 complete (8.7%)

12 months
14 participants with baseline assessment 1st June 2020 onwards (i.e. too soon for 12 month follow up).

Records for 15 participants out of possible 19, but 1 entry was a participant who had never enrolled and 6 had no questionnaires completed:

- SDQ
    - 8 parent surveys complete (42.1%)
    - 7 teacher surveys compete (36.8%)
    - 8 child surveys complete (42.1%)
- Score 15:
    - 0 parent surveys complete (0%)
    - 8 child surveys complete (42.1%)
- IES
    - None
- CRIES8
    - 8 complete (42.1%)
- Edinburgh
    - 8 complete (42.1%)

Appendix D: Pilot Interview Materials

Please note that the pilot materials were not substantively different from those adopted during feasibility. Minimal changes related to the transition from feasibility to pilot phase of the evaluation. One example of each set of amendments is included here for completeness with the changes highlighted.

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC6: PARTICIPANT INFORMATION SHEETS

Parent/Carer/Guardian Information Sheet

NB: Changes to the versions for children and young people and for stakeholders and practitioners were in line with those below. Otherwise, they were the same as versions shown in Appendix B.

1 **Title of study**

A pilot study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: ASSIST

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand what the research is about and what you are being asked to so. Please take the time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

3 **What is the purpose of this study?**

The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. This independent study is being conducted by a team of researchers from the University of Hertfordshire (UH) who are evaluating the work of four family-focused interventions: ASSIST, Family Support, Brandon Centre and RISE Mutual. The key questions for the pilot study are to better understand the factors that support or interfere with the project's successful delivery and, service users' experiences and views of the intervention.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete the interview. You are free to withdraw at any stage (up to 31st March 2022) without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not adversely affect you and/or your child in any way.

5 **How long will my part in the study take?**

If you decide to take part in this research, then you will be invited to talk with an independent researcher from UH to discuss your views and experiences of the support that you and/or your child has received. This may take approximately 40-50 minutes.

6 **What will happen to me if I take part?**

A member of the UH research team will arrange a meeting with you at a mutually convenient date, time and location. You will then be asked to complete a consent form and tell the researcher about your views and experiences of ASSIST.

The conversation with the researcher from UH is confidential. With your permission, what you discuss may be audio-recorded for the purposes of transcription and data analysis, but the recordings will be destroyed at the end of the study (i.e. by 31st August 2022). After the UH researcher has asked you all their questions, they will give you a £10 Love2shop voucher as a 'thank-you' for taking part in the research. You'll have to sign a piece of paper just to say you've received this.

7 **How will my taking part in this study be kept confidential?**

Your confidentiality will be respected at all times. We will use a code rather than your name. Your anonymised data may be kept for up to five years after which it will be securely destroyed by UH. Consent forms will be stored in a lockable cabinet separately to other study data and will be destroyed upon completion of the study (i.e. by 31st August 2022). All electronic files will be stored on UH secure servers which are firewalled and password protected.

8 **What will happen to the data collected within this study?**

We will use the data collected to assess how effective the YEF-funded projects are. UH is responsible for looking after your information and using it properly. No personal data (e.g. names) will be shared and all data will be anonymised. The results of the study will be used to inform future planning for the work of YEF. Any research reports will not identify you individually.

9 **Who has reviewed this study?**

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/SF/UH/04697**

10 **Factors that might put others at risk**

Please note that if, during the study, any unlawful activity becomes apparent that might or has put you or others at risk, UH may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

11 **Who can I contact if I have any questions?**

If you would like further information, or would like to discuss any details personally, please get in touch with us, in writing, by phone or by email: either Brian Littlechild (tel: 01707 284423, email: b.littlechild@herts.ac.uk)Tim McSweeney (01707 284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Thank you very much for reading this information and giving consideration to taking part in this study.

Parent/Carer/Guardian Consent Form: Pilot Interview Phase

A pilot study of a Youth Endowment Fund (YEF) Family Therapy Focused Project

ASSIST

(UH Protocol number **LMS/SF/UH/04697**)

Name of project evaluation leads: *Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).*

Please initial b

1. I confirm that I have read the information sheet dated **{insert date} ({insert version number}**) for the interview phase of the above study. I have had the opportunity to consider the information abou interview, ask questions and have had these answered satisfactorily. ☐
2. I understand that my, and my child's, participation in the interview is voluntary and we are free to withdraw or change our mind at any time without giving any reason, without our support or legal rights bei ected. ☐
3. I understand that the information collected about me and my child will be used to support other r ch in the future, and may be shared anonymously with other researchers. ☐
4. I agree to having the conversation with me and my child audio-recorded. ☐
5. I confirm that I am happy for me, and my child, to take part in the interview. ☐

Name of Parent/Carer/Guardian	Date	Signature

Name of child	Your relationship to the child

Name of Person taking consent	Date	Signature

2 copies – 1 to the parent/carer and 1 to University of Hertfordshire

Please note that for the pilot phase, there were no changes to the topic guide used with families and the debrief remained the same as in the feasibility phase. Changes to the topic guide adopted with professionals have been highlighted below.

Topic Guide for use with Practitioners/Stakeholders

- Can you please describe the main elements of the programme which you are carrying out with children and/or parents (if applicable)? Please describe the main purpose of it, main methods and skills utilised, and the aims of it?

- What you think the main challenges have been in relation to engaging with the parents (if applicable) and young people in terms of meeting the aims of the programme/interventions so far?

- If we were to ask the children/parents/carers in the families what they had hoped for at the beginning programme and whether this was being achieved or not, what do you think they might say?

- What do you think are the main strategies/elements that you have employed in terms of how you have engaged with the children and parents/carers in the families (if applicable)?

- How have you reviewed progress with them, and the outcomes so far of your interventions?

- What's the most reliable and appropriate way of measuring the intervention's outcomes?

- As you know, we are collating statistics in relation to referrals, acceptance, progression rates etc. We would like to explore with you your views on the families referred so far, the appropriateness of those referrals/acceptances, and any issues about engagement. Please tell us about your general views on these areas.

- If we were to ask the children/parents/carers in the families their views on how well they have engaged with the programme, and the value of it, what do you think they might say?

- To what extent do you think the project achieves its intended outcomes (as measured using YEF's 'core measures' and REDCap)?

- If we were to ask them (the families) what the main areas of positive change had been, and why, what you think they might say?

- In terms of the children and/or families accepted on to the programme, to what extent do you think you have managed to keep to the main elements/focus of it, and how much have you had to adapt what you do in relation to the ongoing work in light of reviewing the effectiveness of it?

- Do you think the intervention is ready for full scale efficacy testing (e.g. using a randomised trial)?

Thank you….

Ref No	
Date	
Review Date	
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SCHOOL OF LIFE AND MEDICAL SCIENCES
UNIVERSITY OF HERTFORDSHIRE

Life and Medical Sciences Risk Assessment

The completion of this is an integral part of the preparation for your work, it is not just a form to be completed, but is designed to alert you to potential hazards so you can identify the measures you will need to put into place to control them. You will need a copy on you when you carry out your work

	General Information			
Name	Dr Tim McSweeney	Email address	t.mcsweeney@herts.ac.uk	
Contact number	*Ext 5284*			
Supervisor name (if student)		Supervisor's e-mail address (if student)		
Supervisor's contact number				
	Activity			
Title of activity		A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.		
Brief description of activity		The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. The pilot study will involve a team from the University of Hertfordshire (UH) evaluating the work of four family-focused interventions (ASSIST, Family Support, Brandon Centre, RISE Mutual). The key questions for the pilot study are to better understand: the extent to which the intervention achieves its intended outcomes (as measured using YEF's 'core measures' and REDCap); views on the most reliable and appropriate ways of measuring the intervention's outcomes; whether the intervention is considered ready for full-scale efficacy testing (e.g. using a randomised trial); how, if at all, have aspects of design or delivery changed and adapted (e.g. in relation to enhancing participant recruitment, retention or outcomes); and, service users' experiences and views of the intervention.		
Location of activity		*Online using REDCap (Clinical Trials Database system*		
Who will be taking part in this activity		Dr Tim McSweeney (CI), Prof Brian Littlechild (CI), Dr David Wellsted (CI) and Prof Joanna Adler (PI) from LMS.		
	Types of Hazards likely to be encountered			

X Computers and other display screen	☐ Falling objects	☐ Farm machinery		☐ Fire
☐ Cuts	☐Falls from heights	☐ Manual handling		☐ Hot or cold extremes
☐Repetitive handling	☐ Severe weather	☐ Slips/trips/falls		X Stress
☐Travel	☐ Vehicles	X Aggressive response, physical or verbal		☐ Workshop machinery

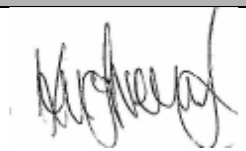
Other hazards not listed above	Vulnerable children (at risk of offending) and their parents/carers. Some respondents may experience distress, feel vulnerable having shared their personal experiences, and be anxious about the use of their accounts to inform the research.

	Risk Control Measures
	List the activities in the order in which they occur, indicating your perception of the risks associated with each one and the probability of occurrence, together with the relevant safety measures. *Describe the activities involved.* *Consider the risks to participants, research team, security, maintenance, members of the public – is there anyone else who could be harmed?* *In respect of any equipment to be used read manufacturer's instructions and note any hazards that arise, particularly from incorrect use.*

Identify hazards	**Who could be harmed?** *e.g. participants, research team, security, maintenance, members of the public, other people at the location, the owner / manager / workers at the location etc.*	**How could they be harmed?**	**Control Measures – what precautions are currently in place?** *Are there standard operating procedures or rules for the premises. Are there any other local codes of practice/local rules which you are following, e.g. Local Rules for the SHE labs? Have there been agreed levels of supervision of the study? Will trained medical staff be present? Etc*	**What is the residual level of risk after the control measures have been put into place?** *Low Medium or High*	**Are there any risks that are not controlled or not adequately controlled?**	**Is more action needed to reduce/manage the risk?** *for example, provision of support/aftercare, precautions to be put in place to avoid or minimise risk or adverse effects*
Computers and other display screen.	Research team.	Prolonged periods of computer use.	All LMS health and safety rules will be followed including 'LMS Health and Safety Codes of Practice'.	Low.	No.	No.
Aggressive response, physical or verbal.	Research team, other people at the interviewees' location.	Being subjected to an aggressive response, or physical or verbal abuse in reaction to some of the issues and topics being discussed.	All LMS health and safety rules will be followed including 'LMS Health and Safety Codes of Practice', the 'BPS Code of Ethics & Conduct (2009)' and 'BPS Code of Human Research Ethics (2014)'.	Low.	No	No. The scope for any harms, hazards and risks to the safety of the investigators are considered negligible as it is envisaged that all data will be collected online (via video conferencing) or over the phone.

Stress.	Participants and research team.	In response to some of the issues, views or experiences reported during the course of an interview.	All respondents will be debriefed and offered referrals and contact details for additional support (e.g. a range of suitable charities, ensuring people are not directed again to services in which they have had negative experiences).	Low.	No.	All fieldworkers are experienced, trauma-informed researchers. As PI, Professor Joanna Adler is available to debrief any members of the research team who experience distress as a consequence of the data gathered during the course of the research (e.g. through qualitative interviews).

List any other documents relevant to this application		The 'BPS Code of Ethics & Conduct (2009)' and 'BPS Code of Human Research Ethics (2014)'.

Signatures					
Assessor name	Tim McSweeney	Assessor signature		Date	*16/09/2021*
Supervisor, if Assessor is a student		Supervisor signature			
Local Health and Safety Advisor Lab Manager	Jon Gillard	Local Health and Safety Advisor/ Lab Manager signature			*16/09/2021*