EVALUATION REPORT

Your Choice

Efficacy Trial Report

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IFS Institute for Fiscal Studies

Anna Freud

YOUTH ENDOWMENT FUND

About the Youth Endowment Fund

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

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

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

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

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About the evaluator

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

The principal investigator (PI) for the project was Professor Imran Rasul, who also led the IFS quantitative evaluation team. The IFS team had responsibility for designing and assessing the feasibility of a quantitative evaluation of Your Choice and the prospects of successfully moving from the pilot study to this full-scale efficacy trial. The IFS team was then responsible for the quantitative evaluation of the efficacy trial. The team included Sarah Cattan, Monica Costa-Dias, Pulkit Bajpai and Vaishnavi Dhas.

The AFC team was led by Professor Julian Edbrooke-Childs and had responsibility for the implementation and process evaluation. The team included Jenna Jacob, Emily Stapley, Emily Orchard, Emily Goodacre, Angelika Labno, Erin Mckeaveney, Grizelda Khaling, Anoushka Kapoor and Ashley New.

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About the Mayor's Violence Reduction Unit

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

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

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

The VRU's Young People's Action Group was involved in co-producing resources and tools for the evaluation of Your Choice and provided regular feedback to ensure young people's perspectives were central to the design and delivery of the study.

About LIIA and London local authorities

Your Choice was designed by the team at LIIA. Hosted by London councils, LIIA is the ALDCS sector-led improvement partnership.

Directors of Children's Services of local authorities are responsible for securing the provision of services which address the needs of all children and young people, including the most disadvantaged and vulnerable, and their families and carers.

LIIA works with a range of partners, including the Department for Education, the Local Government Association, the Society of Local Authority Chief Executives and the eight other Regional Innovation and Improvement Alliances across the country to promote learning, facilitate collaboration, enable governance, leverage investment and share best-practice solutions for mutual benefit. A focus of LIIA's work is to support London's 33 local authorities in tackling the five agreed London-wide priorities, which include adolescent safeguarding.

As part of the study, the team at LIIA supported the development and implementation of Your Choice across London. It also played a key role in promoting and enabling the engagement of local authority teams in the evaluation.

Thirty-one participating local authorities across London took part in the trial, providing local governance and the implementation of both the programme and the evaluation.

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Acknowledgements

The evaluation team would like to thank all the individuals and organisations that have been part of the study. In particular, we would like to acknowledge and honour the ongoing efforts and engagement of the practitioners, Single Points of Contact, clinical leads, trainers and service managers. See Appendix A for the list of participating local authorities and teams. We would also like to thank all the young people who participated throughout the study.

We are indebted to Dr Karla Goodman, Isabelle Gregory and Ben Byrne from LIIA, to other members of the project team at LIIA, to the VRU for their collaboration and, in particular, to Florence Kroll CBE, Chair of the ALDCS, for her support in the evaluation and for chairing the programme steering group.

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The IFS acknowledges funding from the Economic and Social Research Council (ESRC) Impact Acceleration Account and the Centre for Microeconomic Analysis of Public Policy, an ESRC-funded Institute, which provided additional research support. The team declared no other potential interests.

The executive summary presented below is authored by the YEF. The main report is authored by the Evaluators.

Executive summary

The project

Your Choice provides training for youth practitioners in cognitive behavioural therapy (CBT) techniques, who then aim to provide three sessions a week over 12–18 weeks to children at risk of involvement in crime and violence. We know that CBT can protect children from involvement in violence. However, mental health services are stretched, and it can be challenging to engage vulnerable children in therapy. Your Choice aims to overcome these challenges by training youth practitioners – who may have more capacity and ability to engage vulnerable children – to deliver CBT techniques. Your Choice was developed by the London Innovation and Improvement Alliance, acting for the Association of London Directors of Children's Services and supported by the London Violence Reduction Unit. Youth practitioners receive five days of training and a resource pack, followed by monthly supervision from a clinical lead. Sessions with children aim to build trusting relationships and support the child to better understand themselves, develop coping strategies, and disrupt unwanted patterns of behaviour. Practitioners are also provided with a budget for additional activities, such as gym memberships. The project worked with 11- to 18-year-olds assessed by multi-agency risk panels as at risk of harm and exploitation.

YEF funded an efficacy randomised controlled trial (RCT) of Your Choice. Following a previously published pilot study, this evaluation aimed to establish whether Your Choice reduces conduct problems (as measured by the Strengths and Difficulties Questionnaire [SDQ]). This study also tested whether Your Choice improves wellbeing, hyperactivity, self-regulation, social connectedness, prosocial behaviours and identity. The evaluation used an RCT across 31 London local authorities (LAs). Each LA was asked to name at least two teams of youth practitioners. These two teams were randomised into treatment and control teams, with the treatment teams receiving Your Choice training and the control teams delivering business-as-usual (BAU) support. Once children were identified as requiring support, the intention was that they would be referred to the team with the most capacity at that time, recognising that this also depended on the team's specialism and the type of needs presented. There were 968 children in the Your Choice intervention group (supported by 96 teams) and 690 children in the control group (supported by 69 teams). An implementation and process evaluation (IPE) also aimed to examine whether Your Choice was delivered as intended, how it differed from BAU support, barriers and facilitators to delivery and views of the programme. The IPE used 22 interviews with children, interviews or focus groups with 41 professionals, and an analysis of administrative and delivery data. The efficacy trial ran from September 2023 to June 2025. Of the 925 children included in the final analysis, 14% were Asian, 4% of Arab ethnicity, 22% were Black, 25% mixed or multiple group ethnicity, 19% White and 13% from another ethnic group.

Key conclusions
Your Choice demonstrated **a small impact** on reducing self-reported severe conduct problems amongst children. After the programme, children assigned to Your Choice practitioners were very slightly less likely to report severe conduct problems compared to their counterparts who were not assigned to Your Choice practitioners. There is uncertainty surrounding this estimate. This result has **a very low** security rating.
Your Choice showed a small impact on reducing children's self-reported hyperactivity, emotional problems, and peer problems and on improving wellbeing and prosocial identity. It showed a moderate impact on improving children's self-reported emotional self-regulation, social connectedness, and how safe they felt. It showed no impact on children's self-reported prosocial behaviour. Your Choice practitioners perceived that children were less safe. These findings are secondary outcomes that are uncertain and should be treated with more caution.
In the Your Choice group, fewer than 1% of children received 36 or more sessions (the expected number of sessions). 16% of children received no sessions, 47% received 1-9 sessions, and 26% received 10-19 sessions.
Low attendance was caused by a combination of practitioner capacity and the perceived preference of children. Your Choice practitioners reported difficulties fitting three sessions a week into their existing caseloads. Practitioners also questioned whether children needed, or wanted, three weekly sessions.
Children reported mixed reflections on the programme, with some commenting that it supported them to manage emotions, engage with education, and make better choices, while others questioned the impact.

YEF security rating

These findings have a **very low** security rating. The trial was designed to be large enough to detect meaningful impacts on the primary outcome. However, 44% of children who started the trial were not included in the final analysis because they did not complete measures required for the primary outcome analysis. We do not know if the effect found for Your Choice would be the same if the children missing from the final analysis were included. Moreover, the trial relied on LAs always assigning children to the team with the most capacity at the time. Important differences between the children in the intervention and control groups at baseline would indicate that LAs did not strictly adhere to this rule.

Interpretation

Your Choice demonstrated **a small impact** on reducing severe conduct problems amongst children. After the programme, children assigned to Your Choice practitioners were very slightly less likely to report severe conduct problems compared to their counterparts who were not assigned to Your Choice practitioners. This result has a **very low** security rating. Your Choice also showed a small impact on reducing children's hyperactivity, emotional problems and peer problems and on improving wellbeing and prosocial identity. It showed a moderate impact on improving children's emotional self-regulation, social connectedness, and how safe they felt. It showed no impact on children's prosocial behaviour. Your Choice practitioners perceived that children were less safe. These are secondary outcomes and should be treated with more caution. There is statistical uncertainty regarding almost all of the primary and secondary outcomes, and most of the findings are also consistent with there being no impact. Tentative subgroup analysis suggests Your Choice has a more positive impact on White and Asian children, compared to Black children.

Based on monitoring data, very few children attended the expected number of sessions. Fewer than 1% of children received 36 or more sessions (the expected number of sessions). 16% received no sessions, 47% 1–9 sessions and 26% 10–19 sessions. Practitioners struggled to fit three sessions a week on top of their existing workload, and some practitioners reported that children did not want or need three sessions a week. Some also used text or phone contact instead of one-to-one meetings. Activities such as sports, meals and arts were perceived by practitioners as useful in facilitating engagement. However, other challenges hampered delivery (including staff turnover, difficulties reaching evaluation recruitment targets and difficulties accessing funding for activities). In addition, there may have been some control group contamination (with practitioners reporting that 12% of children in the control group had received at least one Your Choice–type session). Practitioners reported that Your Choice provided structure and helpful resources to plan their sessions with children. They also perceived that the programme had a positive impact on children's behaviour, reflectiveness and communication. However, practitioners also noted that Your Choice might not suit all children, with some children mistrustful of the service and not ready for support. The small number of children interviewed reported mixed reflections on the programme, with some commenting that it helped them manage emotions, engage with education and make better choices, while others questioned the impact of the sessions.

Although the wider evidence base has shown that CBT can lead to large reductions in behavioural problems, in this study very small reductions were identified, with high uncertainty. However, the wider evidence does align with this evaluation in demonstrating that good implementation is a key moderator of impact. It is very challenging to engage vulnerable children in CBT, and we must continue to explore how we can better engage these children. This report and the primary and secondary outcome findings only present the findings of one study. When considering implications, frontline professionals, policymakers and service commissioners should carefully consider the process evaluation, the wider evidence base and their own professional judgement.

Summary of impact

Outcome	Effect size	Impact	Evidence security	No. of children	P -value
High or very high range of conduct problems (SDQ)	-0.020 [-0.157, 0.116]	Small		925	0.762

Introduction

Background

The Your Choice programme is a cognitive behavioural therapy (CBT)-enhanced intervention delivered in adolescent services of London's local authorities (LAs) through intensive 12–18-week sessions by specially trained practitioners. Practitioners received training in CBT theory and skills training via a train-the-trainer model and ongoing clinical supervision.

The need Your Choice aims to meet

Therapeutic support for unmet needs, adverse or traumatic experiences and other risk factors may prevent young people from becoming involved in crime and violence or may reduce further involvement (Gaffney et al., 2021). In the UK however, young people with the highest levels of risk factors are currently least likely to access such support in a clinical setting (Crenna-Jennigs and Hutchinson, 2020) due to a variety of factors, including lack of service availability, poor information, inflexibility, complicated referral processes, cultural barriers and stigma, which impact young people's access to clinical services (Brooks et al., 2021).

Due to concerns regarding risk, harm or vulnerability, these young people are, however, likely to be accessing support from other adolescent support or statutory agencies. The Your Choice programme sees this as an opportunity to build on the existing therapeutic resources in multi-disciplinary adolescent services offered by each LA across London. It seeks to fill a practice gap by moving beyond understanding why a child may behave in a certain way to providing tools and techniques to support their psychological health.

Specifically, Your Choice provides bespoke, cohort-relevant training in CBT techniques so that London LA youth practitioners can enhance their practice with practical CBT tools whilst working within each LA's practice framework. It provides a flexible framework so that these tools and techniques can be adapted to incorporate approaches to speech, language and communication needs, autism spectrum disorder and learning disabilities.

The theoretical and scientific underpinnings of Your Choice

Your Choice is primarily informed by the principles and practices of CBT, while seeking to work within a wider understanding of the child's personal/familial history and context and the systems of which they are a part. In this respect, the programme is also underpinned by a range of other psychological theories and best-practice principles relevant to working with adolescents at risk, specifically attachment and developmental theory and child-first and trauma-informed principles. CBT is a widely used treatment for various psychological and behavioural issues in children, adolescents and youth. A key concept of CBT is that an individual's thoughts, feelings, bodily sensations and behaviours are interlinked. The five-factor model of CBT demonstrates the connections among situations, thoughts, emotions, bodily sensations and behaviours in the context of internal or external triggers (e.g. the situation/environment). These five factors are closely connected, so that changes in any one of them can lead to changes in the other factors.

CBT describes a family of interventions. One distinguishing feature of these interventions compared to other approaches, such as social skills training, is the inclusion of cognitive restructuring training. This involves activities and practical exercises that help individuals to recognise cognitive distortions and thinking patterns and apply techniques to modify these distortions. These activities aim to improve the recipient's general

thinking and decision-making skills, such as stopping and thinking before acting and implementing alternative, more desirable responses (Lipsey et al., 2007).

In more traditional (first- and second-wave) CBT, thinking and behaviour are key targets for change, as it is thought that these factors can be most readily influenced, as an individual has more control over those parts of the system. However, rather than changing the content of an individual's thoughts and inner experiences, newer third-wave CBT takes a broader approach and seeks to bring an awareness of and change in the relationship that an individual has with their inner world (Eels, 1997). The Your Choice programme includes tools and techniques from traditional CBT (i.e. thought challenging), as well as third-wave approaches (i.e. emotion recognition and regulation).

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

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

Your Choice is also underpinned by trauma-informed principles, as evident in its infrastructure, design and content. This is in recognition of the high prevalence of exposure to trauma, not only for the young people and the families that are supported through the programme, but also for the practitioners, who are likely to be exposed to vicarious trauma through their work. Within the programme, there are practical tools to improve emotional literacy, supporting the recognition and management of intense emotions, which may be a consequence of traumatic exposures and experiences.

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

Prior evidence on CBT

There exist several systematic reviews of the evidence on the effect of CBT on externalising behaviours, offending and reoffending, including Gaffney et al. (2021), who synthesise three systematic reviews conducted through the 2000s (Koehler et al., 2013; Lipsey et al., 2007; Riise et al., 2021). For brevity, we highlight findings from Gaffney et al. (2021).

A range of different intervention programmes that use CBT techniques or components have been evaluated over the last 30 years. Most programmes evaluated are intensive and occur over a short period of time. A 2021 meta-analysis (Riise et al., 2021) finds that CBT programmes took place over an average of 15 weeks, with a mean number of sessions of 17.3 and a mean intensity of 2.8 hours a week. This is very similar to Your Choice, which aims to deliver three sessions a week over the course of 12 to 18 weeks.

While CBT is intended to be implemented by psychologists, usually with post-graduate training or professional certification in CBT, many CBT or CBT-informed programmes evaluated in the literature involved minimal training for those implementing the intervention. Again, this is a similarity with Your Choice, which provides four-day training (plus a one-day top-up) to youth practitioners working in London LAs.

The effect sizes of CBT interventions on externalising behaviours tend to be large – one meta-analysis (Riise et al., 2021) finds reductions in externalising behaviour from 62 to 74% across the range of behaviours studied. Similar reductions in offending would not be expected because these results are based on rating scales, and most assessors in evaluations were not blinded to conditions. Still, the headline estimate reported in the meta-analysis of Koehler et al. (2013) is an approximate reduction in youth reoffending of 27%.

Behind these average effects lies a lot of variation in estimated impacts, including several studies finding no effect, and the literature reviews highlight several key moderators of effect sizes. Effect sizes are larger when the intensity of the treatment (e.g. number of sessions per week) is higher, when the quality and fidelity of implementation are higher, and when the intervention is delivered to young people at higher risk of recidivism or with higher levels of externalising behaviours. Koehler et al. (2013) also report larger effects of CBT when implemented as part of small-scale `demonstration studies' than when CBT was implemented as part of routine practice. As we discuss below, studies have also reported larger effects of CBT for White participants than for non-White participants.

Racial and ethnic diversity of the Your Choice cohort

Racially minoritised groups are disproportionately represented in the cohort of children and young people Your Choice seeks to support, and there are reasons to think that these groups may particularly benefit from the programme – a motivation for exploring in this report whether impacts differ across racial and ethnic groups.

Young people from Black, Asian and Minority ethnic communities not only experience poorer mental health outcomes but also report poorer experiences with mental health services when compared to the White British population. They are less likely to self-refer via primary care, and, even when they do, are less likely to receive a formal assessment or treatment, more likely to drop out and have poorer outcomes from therapy. Relative to their White British peers, children and young people from Minority ethnic communities are more likely to access mental health services via social care or the justice system, which tend to be compulsory (Youth Endowment Fund [YEF], 2025) and are precisely the route that Your Choice leverages to provide support to your people. There is evidence that cultural barriers that impact access to clinical services, such as cultural perceptions of mental health, a lack of understanding of the devastating and negative effects of racism, underrepresentation of global majority clinicians stigma associated with mental health, are particularly prominent among racially minoritised groups (YEF, 2025). Hard-to-reach services with lengthy waitlists, strict attendance policies, and a lack of interpreters can also impact accessibility.

Young people in the cohort targeted by Your Choice will therefore be likely to benefit from the opportunities, tools and techniques offered by the programme to improve their mental wellbeing if these are delivered in a way that is accessible and available to them by those who are culturally curious, representative and/or familiar.

While CBT has been shown to be broadly effective for ethnic minorities, meta-analyses suggest that its effects may be somewhat weaker for these populations compared to White clients (Huey et al., 2023). Rathod et al. (2019) argue that because CBT was developed in the West, its core concepts may not be acceptable or effective for people from diverse cultural backgrounds unless they are adjusted to align with their unique life experiences, belief systems and assumptions. Experiences of racism have also been shown to be a cumulative risk factor for developing mental health problems, suggesting that therapists working with service users should be confident in their ability to establish the necessary rapport to ask about these experiences and be able to incorporate this information into their support (Beck, 2019). The literature provides guidance for service managers and therapists to develop their confidence to address issues around race, ethnicity and culture and to deliver culturally responsive therapy to service users from Minority ethnic communities (Naz et al., 2019; Samuel and Simonds, 2025). This includes recognising and questioning their own avoidance behaviours and implicit biases, as well as recommending that for therapists to do this effectively they will need training and supervision delivered in skilled, safe and non-judgemental settings.

In light of these insights, Your Choice is designed to support and enable accessibility, explicitly addressing cultural barriers and placing the individual and their cultural needs, aspirations and interests at the centre of the programme. The programme is delivered through the existing social care workforce, which is more diverse than the psychologist population (68% of social care case workers in London are from Black and minority ethnic backgrounds, compared to 16% of practitioner psychologists nationally; HCPC, 2022). As Black, Asian and Minority ethnic children are more likely to access mental health services via social care or the justice system, this provides an opportunity to upskill the workforce where support is more likely to be accepted. The flexibility of the programme also allows for the intervention to be adapted to meet the needs of the individual. Your Choice clinical leads are encouraged to consider cultural adaptations with their Your Choice coaches to support their work with each young person. This might include activating culturally important networks or using culturally adapted CBT. To support delivery, Your Choice coaches are encouraged to activate the network around the young person. Sharing the tools and techniques with those most important to the young person can support the accessibility and sustainability of the intervention, both within and beyond the formal 12–18 weeks, leading to lasting impact. It is hoped that this could have a cumulative effect by upskilling members of the community, where minoritised groups are more likely to seek support.

Your Choice practice is underpinned by a set of core guiding principles, emphasising the importance of culturally sensitive practice. Your Choice practitioners and clinicians are encouraged to model cultural humility and to be explicit about culture. These are reflected in the Your Choice practice guideline 3, which stipulates the following:

> *Young people and their families need services to be aware of and overcome cultural barriers to access support. Your Choice is committed to nurturing a culturally curious workforce who are explicit and prioritise understanding and addressing the influence of their own culture, and that of the families and young people that they work with. The Your Choice programme will be uniquely adapted for each young person according to their individual needs and aspirations, which includes cultural influences.*

The importance of a young person's culture (which may include youth culture) should be reflected in the approach and delivery of the programme.

To activate prosocial activities and behaviour, Your Choice practitioners work closely with young people to develop a shared understanding of their values and aspirations, including cultural aspects. Understanding the things that are important to a young person allows for the activation of behaviours and networks that are culturally relevant and meaningful to them.

The importance of culture is also emphasised within the Your Choice training, including in the train-the-trainer training. In addition, Your Choice trainers attended training delivered by Power the Fight "Becoming a Culturally Sensitive Organisation". Beyond the training room, during monthly clinical supervision, Your Choice coaches are encouraged to reflect on the influence of culture in their work – both that of the young person and their own – to ensure that this is actively considered in each young person's formulation and Your Choice practice.

In sum, the Your Choice programme was designed with great consideration of the ethnic and racial diversity of the groups of children and young people it aims to serve, and there are reasons to believe that children and young people from different racial and ethnic groups may benefit differently from Your Choice. To this end, the evaluation will include an exploratory analysis of how impacts might differ across racial and ethnic groups.

Overview of the evaluation design

The London Young People Study (LYPS) is a mixed-method evaluation of the Your Choice intervention. The impact evaluation is based on a two-armed cluster randomised controlled trial (RCT), where the unit of randomisation is the team of youth practitioners. That is, teams supporting young people eligible for Your Choice are randomly assigned to train in and deliver Your Choice (treatment group) or to support young people following business-as-usual (BAU) practices (control group). Teams randomised out of training during the efficacy trial will be offered training in Your Choice later. This was explicitly agreed with LAs, given the reservations they expressed about the randomisation protocol. It therefore seems unlikely that control teams would change their behaviour towards young people in the anticipation of being trained in Your Choice in the future. LAs also have an obligation to the young people who are referred to them to deliver statutory services according to BAU processes.

The trial was designed as such because individual-level randomisation of young people would interfere with the usual delivery of statutory services in ways that would be impractical for and unacceptable to LAs. A key aspect of LAs' objections to the randomisation of young people was that they could not guarantee the availability of allocated spaces, given the limited capacity of teams and how that capacity fluctuates over time, rendering the process difficult to manage and likely to create serious disruptions to services.

Instead, the RCT design was drawn up under the expectation that the assignment of young people to teams was based on team availability at the time of referral, conditional on presented needs and the team's specialism in a system that works at capacity. The one exception to this rule is for young people returning to LA services after a brief interruption, who would be assigned to the same team that previously worked with them. Such an assignment rule ensures that assignments are independent of the team's status regarding Your Choice training.

The evaluation of Your Choice was designed taking into account the racial and ethnic diversity of the cohort involved in the trial. First, demographic data were collected from LA administrative data to capture, as accurately as possible, the racial and ethnic composition of the cohort. Second, the recruitment materials (e.g. information sheets, privacy notices, recruitment video) and the data collection instruments were developed with the input of the research Young People's Advisory Group (YPAG), which was diverse in terms of race and ethnicity. The scales used in the quantitative survey have been validated on diverse populations. Moreover, the evaluation team, alongside the project team, developed an alternative scale called 'Check point' to measure the young person's safety risks, as perceived by themselves and as perceived by their practitioners. This scale was developed by the project team, drawing on its ample experience working with children eligible to participate in the trial and talking about the risk of harm with young people, with advice from the YPAG. Finally, the analysis recognises that the impact of Your Choice may differ across racial and ethnic groups and includes a subgroup analysis of impacts by race and ethnic groups.

The implementation and process evaluation (IPE) exploits both quantitative and qualitative methods, including the collection of process data on the delivery of Your Choice and BAU support and qualitative interviews with LA staff, trainers and young people involved in the delivery of Your Choice.

Findings from the internal pilot

The implementation and delivery of Your Choice was piloted in the context of youth services delivered by London LAs during the second half of 2022 and early 2023. The aim of the pilot was to train and initiate youth services in LAs in the delivery of Your Choice in an experimental setting to inform the feasibility and practical aspects of delivering the intervention and implementing a successful efficacy trial. Specifically, the objectives of the pilot study were:

- To assess the feasibility of implementing an effective data collection exercise that supports the quantitative evaluation of Your Choice
- To examine how the Your Choice intervention is implemented, the fidelity of delivery and what helps and hinders implementation
- To assess the adherence of LAs and youth practitioners to randomisation and explore whether a design based on team-level randomisation was likely to provide a robust basis for causal inference
- To pilot study outcomes and evaluation methods, assess the parameters for conducting an efficacy evaluation, assess whether operational progression criteria have been met, and, if so, develop a full protocol for an appropriately powered efficacy study

Detailed findings from the pilot study are available in the Your Choice Interim Pilot Report. We summarise here findings from the pilot phase, which were critical in shaping the design and implementation of the efficacy phase.

During the pilot, LAs largely adhered to the randomisation protocol concerning the assignment of teams to training conditions. Analysis of young people's allocations to trained versus untrained teams revealed a balanced distribution of baseline characteristics across treatment arms, which was consistent with the hypothesis of a system working at capacity. This was further reinforced by qualitative data highlighting that allocation decisions primarily hinged on team capacity at the point of referral rather than on individual characteristics or perceived potential benefits of participation in Your Choice. This supported the validity of the proposed evaluation design, predicated on a near-random allocation process, though it is important to

acknowledge that the quantitative analysis focused only on observable baseline characteristics and was naturally unable to rule out selective assignment on characteristics not recorded in the available data.

Qualitative insights indicated that some practitioners occasionally considered potential benefits and perceived risk levels when assigning young people to teams. This practice violates the evaluation design principle, which mandates assignment based strictly on team availability at referral time, except for cases involving young people returning to services after brief interruptions, who rejoin their previous team. While this approach's impact was not evident from baseline data (where characteristics appeared balanced), even limited evidence of its occurrence led to intensified training for LA staff, particularly stressing strict adherence to RCT protocols throughout the efficacy trial.

Data from session records and qualitative analyses demonstrated high fidelity in implementing the intervention. Teams trained in Your Choice provided more frequent sessions focused specifically on CBT methodologies, which differed significantly from standard BAU practice.

Recruitment into the pilot was lower than initially projected, which influenced expectations regarding experimental group sizes for the subsequent efficacy trial, necessitating revisions to the power calculations outlined later in this report.

Data sharing between councils and evaluators experienced inconsistencies and significant delays, notably in session forms that are crucial to the IPE. Collection of endline survey data from young people and practitioners similarly suffered from delays and gaps. To address these data concerns, a new mobile-friendly online interface was developed to streamline practitioners' form completion and facilitate oversight by single points of contact (SPoCs).

All data collection was conducted in the same way in treatment and control groups. To enhance the timeliness and completeness of endline data, critical for primary outcome measurement, the endline youth survey administration was revised to occur within regular sessions, supervised by youth practitioners and supplemented by audio assistance for participants facing reading challenges, along with the option for the surveys to be sent securely via a WhatsApp message to the young people. This contrasts with the initial pilot approach, which involved contacting participants outside regular sessions with peer researcher assistance; the revised data collection approach allowed for significantly higher baseline and endline data completion rates during the efficacy phase relative to the pilot phase.

Securing collaboration from control teams was particularly challenging, largely due to practitioners' perceptions that participation offered fewer immediate benefits for themselves and the young people they supported. This led to lower adherence to data collection protocols among control groups. Consequently, during the efficacy phase, considerable attention was given to ensuring practitioners in control teams felt integral to the evaluation process, actively participated and were recognised as essential stakeholders in the trial's success.

Initially, the intervention was planned to commence immediately following recruitment, involving 12 weeks of delivery with three weekly sessions (including calls, in-person meetings, gym visits and psychoeducation sessions with parents/carers), each lasting approximately 45–60 minutes. The pilot revealed practical challenges with adhering strictly to this schedule – challenges that remained during the efficacy trial, as detailed below. Delivery typically began within two weeks of recruitment and extended over approximately

16 to 18 weeks, generally concluding between weeks 17 and 20. Consequently, the efficacy trial and accompanying data collection were structured to reproduce the extended timeline implemented in practice over the pilot period, explicitly defining programme delivery from weeks 1 through 20 post-recruitment, with a flexible timeline, thereby aligning the implementation conditions in the efficacy trial with those of the pilot period.

Intervention

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

Table 3. Intervention description

Item	Description
BRIEF NAME	Your Choice
WHY	Young people at risk of violence (those most at risk) are those in most need of therapeutic support but most unlikely to receive it. We need to shift how we offer support to young people so that they can access it within their community within a broader context of support and behavioural change. This can be best delivered through a holistic community model involving all relevant partners.
WHAT	Your Choice is for any child aged between 11 and 18 years old who is assessed as being at medium or high risk of harm/vulnerability as a result of extra-familial harm and has been considered by a multi-agency panel (typically a Multi-Agency Child Exploitation panel/pre-Multi-Agency Child Exploitation panel). Your Choice includes three main components: 1. Upskilling practitioners via five days of training for youth workers (delivered in a cascading model) and the provision of a handbook and resources to support delivering training sessions. 2. Intensive work with children to build an authentic and trusting relationship with the practitioner and create a safe space where young people can grow, understand and formulate their needs and goals. Specifically: • Young people in the treated arm will receive the equivalent of three x weekly meetings with a trained youth practitioner for 12 weeks over the 20 weeks after recruitment. • The sessions will deliver an accessible clinical intervention, focusing on emotional literacy, emotion regulation, understanding cognitive processes and strategies for managing intense feelings. • Sessions will be informed by cognitive behavioural therapy tools and techniques, such as goal setting (using the Goal Based Outcome Tool) and practical support with activities to achieve these goals. 3. Monthly clinical supervision by clinical leads hired by local authorities.
WHO PROVIDED	Existing workforce: This included youth practitioners, youth workers, social workers and youth justice workers hired by the local authorities as practitioners in the teams involved in the study.
HOW	Individual or work with the family

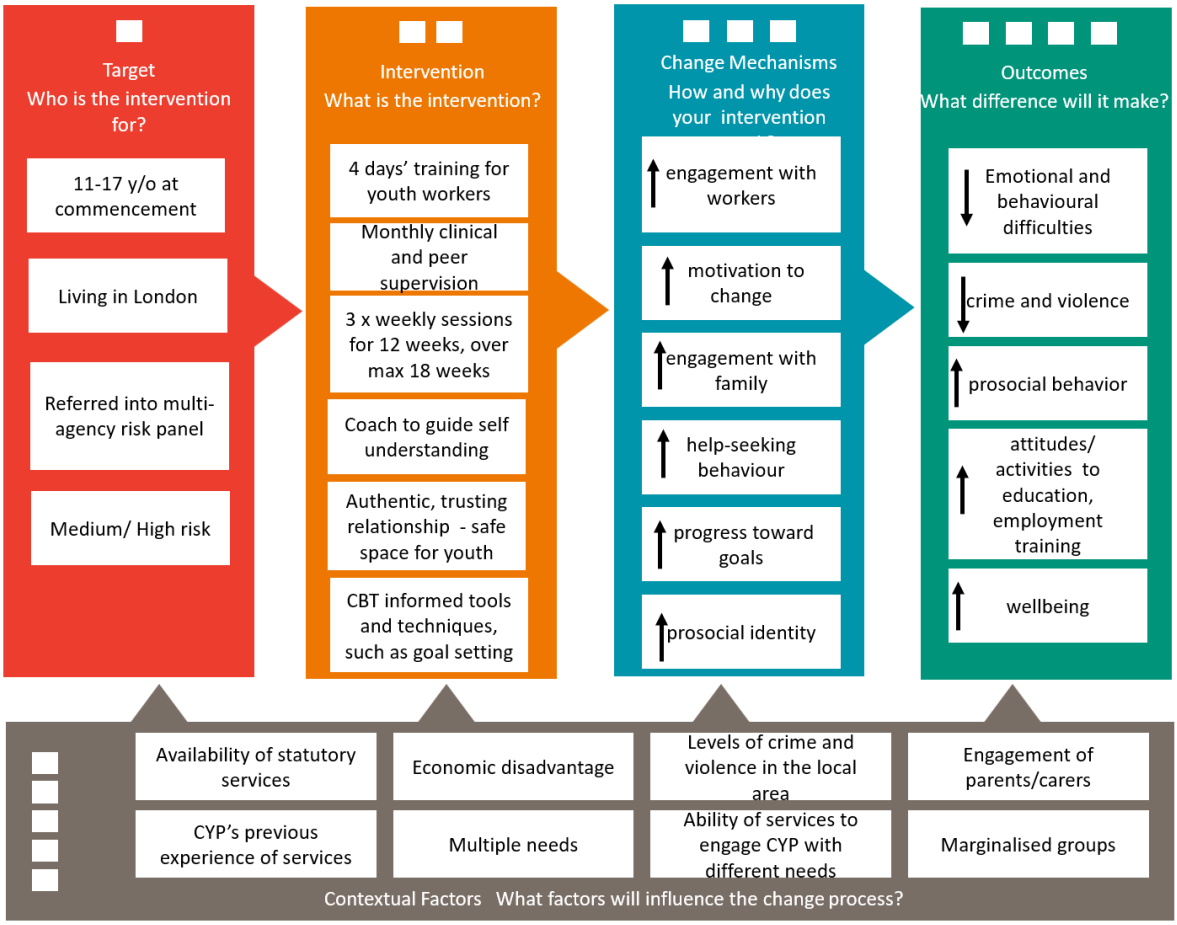
WHERE	A range of locations accessible to the young person so that they are engaged in the places they want to be engaged: mainly community settings, such as youth centres, cafes and gyms.
WHEN and HOW MUCH	The intervention originally projected the delivery of three weekly sessions for 12 consecutive weeks (calls, focused sessions, trips to the gym and work with parents/carers for psychoeducation): 45–60 mins per session (possibly longer). The pilot demonstrated that this intensity was difficult to achieve. More realistically, the same total number of sessions was delivered over an extended period of 18 weeks from recruitment.
TAILORING	To facilitate sustainability and meet local needs, it is important that local authorities own Your Choice; it will build on existing services and delivery for this cohort of young people, which will vary between different local authorities. For example, Your Choice can be delivered in different services across local authorities, depending on local authorities' perceptions of where it would have the most impact.
MODIFICATIONS	Findings from the pilot prompted some adaptations to the programme: • The age range was extended to include young people who would turn 18 years old during the programme. • The endline youth survey will be administered during a regular session in the presence of the youth practitioner to avoid long delays in data collection and improve response rates; questionnaires not filled out in this way will be sent via WhatsApp. • The effective delivery period of Your Choice to young people was extended from 12 to 18 weeks in view of the practical limitations of concentrating the treatment in a shorter period. • Failure by a few allocators to exclusively follow the capacity and historical assignment rules when assigning young people to teams led to the launch of a large training campaign ahead of the efficacy trial to remind all those involved about the assignment, delivery and data collection protocols and the importance of following them strictly.
HOW WELL	To test fidelity monitoring during the efficacy trial, we used qualitative interviews with practitioners and young people and analysed process data on the content of each session and the occurrence of clinical supervision sessions.

Further information about delivering the intervention is available on the Your Choice page of the London Innovation and Improvement Alliance (LIIA) website (https://www.liia.london/your-choice). Practitioners trained in Your Choice could also access a secure portal from there, providing them with additional tools to deliver Your Choice. The training of trainers was provided by Dr Karla Goodman, Director of Practice Lead at LIIA and developer of the programme. Trainers were primarily clinical leads and team managers.

Logic model

The intervention is hypothesised to work through several mechanisms, described in the logic model below. The logic model is the same as the logic model designed before the pilot trial, except for one of the mechanisms, which was reformulated from increased help-seeking behaviour to increased self-understanding and the use of self-management strategies. This change was informed by pilot qualitative findings.

Figure 1. Your Choice's logic model



Control condition

The control condition is the BAU support that young people who meet the eligibility criteria for receiving Your Choice would receive in the absence of the evaluation. BAU varies between LAs and ranges in terms of intensity and the techniques practitioners use. The interpretation of the treatment effects is then relative to these BAU practices across LAs (which need not be identical benchmarks but are the most relevant for external validity). The monitoring data we collect as part of the evaluation enables us to describe the support received in BAU and contrast it with Your Choice.

Incentives or restrictions for those in each group

There are no incentives for or restrictions on the delivery of the Your Choice intervention among young people allocated to a trained team. Study participants received a £10 voucher upon completion of the baseline young person questionnaire and £25 upon completion of the endline young person questionnaire.

Period when the intervention is being delivered

Delivery of Your Choice starts with the training of teams in CBT-informed tools and techniques, which took place during three periods:

- Home Office stage: The first training phase started in December 2021 and saw a small number of teams across 32 LAs in London trained in and delivering Your Choice. In five of these LAs, the trained team was randomly selected from two candidates (in all of the other 27 LAs, the trained teams were non-randomly selected). The young people recruited in these teams during the pilot and efficacy stages were included in the evaluation.

- YEF (internal) pilot stage: Training was extended to additional teams during the spring of 2022 in preparation for the YEF pilot trial of Your Choice between August 2022 and March 2023. In the majority of cases, the selection of treated and control teams was randomised within LAs. In some LAs, however, such randomisation was not possible because they could not name two untrained teams to participate in the pilot. Only young people recruited in randomised teams were included in the evaluation.
- YEF efficacy stage: LAs put forward two or more untrained teams for randomisation during this stage. For the efficacy trial, the delivery of training for randomly selected teams happened on a rolling basis between June 2023 and April 2024. Following the training of the teams, the assignment of young people to treatment and control teams and the delivery of Your Choice expanded accordingly, starting in January 2022 and continuing uninterruptedly, but with an increasing number of teams, until the end of the efficacy trial in December 2024. Delivery in the pilot and efficacy trials was funded by the YEF. From April to July 2023, i.e. between the end of the pilot trial and the start of the efficacy trial, the Violence Reduction Unit (VRU) funded a transitional phase to ensure LAs could continue delivering the intervention to young people during this time.

How the intervention providers were assigned to groups

The treatment and control groups are defined at the team level based on whether a team was assigned to be trained in Your Choice. Once a team was trained at any of the three training stages, it could only act as a treatment team in subsequent phases. If a team acted as a control team in one stage, it could be re-randomised in the next stage and possibly become a treatment team.

Evaluation objectives

The objectives of this mixed-method evaluation were informed by the logic model and designed to reflect the complex set of relationships between the Your Choice intervention and the primary and secondary outcomes, the mechanisms underlying these relationships and the importance of contextual factors in determining the strength of these relationships.

Impact evaluation

As set out in the evaluation protocol, the impact evaluation part of the study aims to answer four research questions (RQs):

RQ1. Can an intervention informed by CBT techniques and practices and delivered by trained frontline practitioners reduce conduct problems among young people most at risk of being affected by violence?

This is the main RQ, focusing on the impact of Your Choice on the primary outcome, which the trial is powered to detect. The primary outcome is an indicator for scoring in the high and very high range on the conduct problems subscale of the Strengths and Difficulties Questionnaire (SDQ), measured at endline using the participant survey administered at week 20 after recruitment. The null hypothesis we tested is that there is no difference in this outcome between young people allocated to Your Choice and those allocated to BAU.

RQ2. Is there a difference in offending behaviour between young people allocated to work with a team of practitioners trained in Your Choice in comparison to young people allocated to work with a team of practitioners delivering BAU support?

The outcome of interest is whether participants are arrested within 16 months after recruitment, as recorded in the Police National Computer (PNC) database. This outcome was not chosen as the primary outcome of the trial because its relatively low frequency of criminal activity presents power challenges for detecting impacts, and the inherent delay in obtaining crime data necessarily would have substantially postponed the analysis. Due to these considerations, this outcome was classified as a secondary outcome, and the examination of the intervention's impact on it will be reported in a future analysis.

To start answering RQ2 in this report, the analysis examines the impacts ON self-assessed and practitioner-assessed levels of safety, measured at endline as part of the surveys completed by young people and practitioners at week 20 following recruitment. The analysis is not powered to detect impacts on these scores, however, so these outcomes are included as secondary outcomes.

To shed light on RQ2, the null hypotheses tested are:

(i) There was no difference in arrest probabilities between young people allocated to Your Choice and those allocated to BAU (to be reported in future work).

(ii) There was no difference in the self-assessed and practitioner-assessed likelihood of young people engaging in risky behaviour between those allocated to Your Choice and those allocated to BAU (reported in this report).

RQ3. What are the mechanisms through which Your Choice works? Specifically, in comparison to young people allocated to BAU support, do young people allocated to work with a team of practitioners trained in Your Choice see improvements in behaviour and externalising difficulties, gain higher wellbeing and emotional self-regulation, have stronger relationships with their sources of social support, and display more prosocial behaviours?

To shed light on RQ3, the null hypotheses tested are that there was no difference in a set of secondary outcomes, measuring wellbeing, emotional self-regulation, social connectedness and prosocial behaviours (detailed in the methods section below) between young people allocated to Your Choice and those allocated to BAU.

RQ4. Do the impacts of being allocated to a team trained in Your Choice differ by gender, age, ethnicity and the level of risk assessed by the practitioner?

To shed light on RQ4, we repeat the analyses performed to answer RQ1 and RQ2 on subgroups defined along these dimensions.

IPE

The IPE part of the study aimed to answer the following RQs:

IPE-RQ1: To what extent is Your Choice delivered as intended?
IPE-RQ2: To what extent is the delivery of Your Choice different from and similar to BAU?
IPE-RQ3: What are the barriers to and facilitators of delivery?
IPE-RQ4: What are young people's and practitioners' views and experiences of Your Choice (acceptability, impacts and mechanisms)?
IPE-RQ5: What are practitioners' views of the sustainability of Your Choice?

Ethics and trial registration

Ethics

We submitted a high-risk ethics application to the University College London Research Ethics Committee, and it was approved on 1 August 2023 (Project ID 5114/014). Several amendments were submitted to modify the content of the information sheets, consent forms and questionnaires; slightly modify the quantitative and qualitative data collection processes; and extend the duration of the data collection period. All amendments were approved.

Agreement to participate

Eligible young people were those allocated to be supported by teams participating in the efficacy phase and who met the following eligibility criteria:

a) Age 11–17 years old (inclusive) at the time of recruitment (during the efficacy phase, young people needed to be 17 at recruitment but could turn 18 during the study). This contrasts with the pilot trial, during which children and young people were only allowed to be recruited into the study if they were 17 throughout their entire participation in the study.
b) Referred to adolescent safeguarding services and assessed to be at medium to high risk of contextual harm. The evaluator required this assessment to be quality assured by a multi-agency risk assessment panel or through local quality assurance practices. Once a young person was identified as eligible for the study, agreement to participate was obtained through the following process:

- The young person's lead practitioner informed them about the opportunity to participate in the study. The practitioner showed them the recruitment video animation, provided them with a copy of the information sheet and discussed with them the content of the information sheet and privacy notice. If the young person was 11–15 (inclusive), the practitioner also provided their parent(s)/guardian(s) with the parents' information sheet and had similar discussions with the parent(s).
- If interested in participating in the study, the young person was then invited by their lead practitioner to sign the young person's consent form. If the young person was age 11–15 at the time of recruitment, their parent/guardian was also required to sign the parental consent form.

Trial registration

The pilot trial was registered on the American Economic Association AEA RCT registry on 12 July 2022 (AEARCTR0009611). The efficacy trial was registered on the ISRCTN registry on 30 August 2023 (ISRCTN69049265). Details can be found here for the pilot trial and here for the efficacy trial.

Data protection

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

The evaluation team developed a privacy notice for the young people and their parents and a privacy notice for practitioners to collect information about them through surveys and the LA workbooks. The project and evaluation teams worked with the Information Governance for London group to develop a data-sharing

agreement between the LAs and the evaluator to allow LAs to share administrative data on participants and practitioners through the LA workbooks. The information sheet for the young people (and their parents) and the recruitment animation video summarised key elements of the privacy notice. See Annexe B for a copy of the privacy notice. The information collected during the trial was stored by the Institute for Fiscal Studies (IFS) or the Anna Freud Centre (AFC) for the purposes of this project. This data, for the most part, was not anonymous, but both organisations have strong measures in place to ensure data protection. Data is stored on the network of the IFS in a secure folder with access restricted to named researchers. The IFS information security management system is ISO27001 compliant, and the IFS has an information classification and handling policy, which sets out comprehensive guidelines for handling all types of data and information (including highly confidential information). The AFC has similar IG policies, and all information is held on the secure AFC servers, with only approved researchers having access. All project team members have followed and will continue to follow strict procedures in this policy and have adhered to the IFS/AFC Information Security Policy when using or collecting data. All project team members have received appropriate General Data Protection Regulation training.

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

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

Data subjects' rights

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

Purposes of data processing

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

Data retention

The privacy notice also specified that the data stored by IFS, which includes young people's and practitioners' answers to questionnaires and LA workbook data (and, in the future, may include PNC records from the Ministry of Justice), would be stored for a minimum of 10 years to allow the evaluation team to look at the long-term effects. After 10 years, the IFS will carry out a review to see whether there is still useful

work that can be done with the data and commit to deleting it at any time when they no longer need the data for this research project.

Data processing roles

As specified in the privacy notice, the IFS and AFC are joint data controllers at the start of the study. Upon the end of the study, the data will be handed over to the YEF for archiving purposes, making the YEF another data controller. At this stage, the AFC will no longer become a data controller. A joint data controlling agreement is in place between the two institutions.

In the efficacy trial, a data processing agreement between IFS and the data lead at LIIA was established to allow this person (and someone on their team to act on their behalf during periods of leave) to support LAs with their completion of such data.

A data processing agreement between IFS and the data lead or SPoC in each LA was also established in order to allow these individuals to support practitioners with their duties related to the completion of consent forms and questionnaires.

Lawful basis

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

Project team and stakeholders

The evaluation team is a partnership between IFS and AFC. Professor Rasul (IFS), as principal investigator, has overall responsibility for the project. The IFS team led the quantitative evaluation. The AFC team led the qualitative IPE.

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

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

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

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

Methods

Trial design

The full study comprises an internal pilot trial and an efficacy trial. The pilot started in August 2022, with teams randomly assigned to Your Choice training in December 2021 and later in Spring 2022. Young people assigned to the treatment and control arms during the pilot period were provided with the exact same treatment conditions as in the efficacy phase, which started one year later in August 2023, with additional teams randomly assigned to training in the Spring and Summer of 2023.

The assignment mechanism of young people to teams followed the same rule during the pilot and efficacy trials. The data collected for participants in both periods was similar and included background data, needs presented, session data, and baseline and endline surveys. All primary and secondary outcomes were collected for participants following the same procedures during the pilot and efficacy trials. The consistency in design across the two periods allows us to treat the pilot as internal.

The efficacy and pilot trials were designed as cluster RCTs, whereby teams of youth practitioners were randomly assigned to either the CBT training and delivery of Your Choice or BAU. The unit of randomisation was therefore the team of youth practitioners within an LA, and there are two trial arms – control and treatment. Teams in the control arm are called control or BAU teams throughout the report; teams allocated to Your Choice training and delivery are referred to as treatment, intervention or Your Choice teams interchangeably. Teams randomised out of Your Choice training during the pilot trial continued offering young people BAU support, which, in most cases, involved less structured and lighter support than Your Choice. A subset of these teams entered the randomisation pool in the efficacy trial: some of them were randomly selected to switch to training and delivering Your Choice, while others were randomly selected to continue delivering BAU.

The design does not require that the young people be randomly assigned to teams within services. Instead, it follows the usual process of assigning the young people to teams, which is based on workload considerations in a system that works at capacity. Specifically, given their presented needs, a young person is assigned to the team that has the most spare capacity at the time they are referred to the LA services among the teams prepared to deal with the young person's specific needs. **If applied strictly**, this rule effectively guarantees as-good-as-random assignment, in that the assignment of the young people to teams is independent of the team status regarding Your Choice training because it depends only on team availability at the time the young person happens to be referred to LA services, conditional on the match between the presented needs of the young person and teams' specialisms (recall that teams were randomly assigned to Your Choice training, so training status does not depend on specialism). After assignment to a team, the young people are recruited into the study by their allocated practitioner, who is a designated member of the team with special responsibility for the young person. Recruited young people participated in the trial and had their data collected and shared.

While it is impossible to know for sure whether the above allocation rule was applied strictly during the efficacy phase of the trial, and the pilot study failed to provide definite evidence on the allocation mechanism, in this report, we present statistics testing whether the characteristics of children and young people in the control and treatment groups were balanced. Any systematic imbalance could suggest that LAs did not comply with this allocation rule.

Table 4. Trial design

Trial design, including the number of arms		Two-arm, stratified cluster randomisation of teams Randomisation of young people to treatment arms relies on the additional assumption that the assignment of young people to teams is strictly based on team capacity at the time of referral and is, therefore, as good as random.
Unit of randomisation		Teams of youth practitioners
Unit of Observation		Young people
Primary outcome	Variable	Conduct problems
	Measure (instrument, scale, source)	An indicator for scoring in the high or very high range of the conduct problems subscale of the Strengths and Difficulties Questionnaire Measured as part of the endline young person survey, administered at week 20 after recruitment during a session with the practitioner
Secondary outcome(s)	Variable(s)	Offending activity, self-reported and practitioner-reported perceptions of young person's safety, social connectedness, internalising behaviours, hyperactivity, prosocial behaviour, prosocial identity, mental wellbeing and emotional self-regulation
	Measure(s) (instrument, scale, source)	*Criminal activity*: recorded arrest in the Police National Computer during the period of 16 months after recruitment. *Self-reported and practitioner-reported perceptions of the young person's safety*: the young person and practitioner versions of Checkpoint, an instrument developed by the project and research team to measure young people's perceptions of safety, measured at endline as part of the young person questionnaire, 20 weeks after recruitment *Social connectedness*: Social Connectedness Scale – Revised (SCS-R), measured at endline as part of the young person questionnaire, 20 weeks after recruitment *Internalising behaviours (emotional difficulties and peer difficulties):* emotional difficulties and peer difficulties subscales of the Strengths and Difficulties Questionnaire (SDQ), measured at endline as part of the young person questionnaire, 20 weeks after recruitment *Hyperactivity*: hyperactivity subscale of the SDQ, measured at endline as part of the young person questionnaire, 20 weeks after recruitment.

		Prosocial behaviours: prosocial behaviour subscale of the SDQ, measured at endline as part of the young person questionnaire, 20 weeks after recruitment. *Prosocial identity*: Prosocial Identity Scale (PIDS), measured at endline as part of the young person questionnaire, 20 weeks after recruitment *Wellbeing*: The Short Warwick–Edinburgh Mental Well-being Scale, measured at endline as part of the young person questionnaire, 20 weeks after recruitment *Emotional self-regulation*: Trait Emotional Intelligence Questionnaire – Adolescent Short Form self-regulation subscale, measured at endline as part of the young person questionnaire, 20 weeks after recruitment
Baseline for primary outcome	Variable	Conduct problems
	Measure (instrument, scale, source)	Indicator for scoring in the high or very high range of the conduct problems scale from the SDQ, measured as part of the baseline young person questionnaire
Baseline for secondary outcomes	Variable	The secondary outcomes were measured at baseline for all secondary outcomes except wellbeing and emotional self-regulation, which were not collected as part of the baseline young person questionnaire.
	Measure (instrument, scale, source)	*Self-reported and practitioner-reported perceptions of young people's safety*: young person and practitioner versions of Checkpoint: A safety scale for young people, which is an instrument to measure young people's perceptions of safety that was developed by the research team, measured as part of the baseline young person and practitioner surveys, administered in week one after recruitment *Social connectedness*: SCS-R, survey of the young person following consent before Your Choice starts (in some cases, some form of BAU work/support would have already taken place), measured as part of the baseline participant's survey, administered in week one after recruitment, before the start of Your Choice *Internalising behaviours (emotional difficulties and peer difficulties):* emotional difficulties and peer difficulties subscales of the SDQ, measured at baseline and endline as part of the participants' surveys administered following recruitment and at week 20 after recruitment, respectively

		Hyperactivity: hyperactivity subscale of the SDQ, measured at baseline and endline as part of the participants' surveys administered following recruitment and at week 20 after recruitment, respectively *Prosocial behaviours*: the prosocial behaviour subscale of the SDQ, measured at baseline and endline as part of the participants' surveys administered following recruitment and at week 20 after recruitment, respectively *Prosocial identity*: PIDS, measured at baseline and endline as part of the participants' surveys administered following recruitment and at week 20 after recruitment, respectively

Research team's positionality

The research team included a diverse range of characteristics, backgrounds, disciplines (e.g. economics, psychology, quantitative methods and qualitative methods) and levels of seniority. The close collaboration between the impact and IPE teams throughout every part of this evaluation ensured we achieved a comprehensive understanding of the programme. It also meant that our commitment to highlighting the voices of young people and staff through different means was achieved. The research team comprised staff with high levels of educational qualifications. Nonetheless, diversity in perspectives was achieved through working with a young person's peer researcher and YPAG throughout the evaluation, bringing expertise of lived experiences.

Equity, diversity and inclusion (EDI) was actively considered throughout the design and delivery of the research. In the pilot study, we changed our approach to assessing crime and violence based on feedback from experts whose experience indicated that the original measure was stigmatising for young people. Our peer researcher and research YPAG informed our approaches to data collection to ensure we were being inclusive of the potential needs of our target cohort of young people. They helped us interpret our IPE findings and named our themes from the interviews with young people.

Through the co-design of the evaluation, the pilot study and throughout the efficacy study, we worked with LAs and staff to support accessibility and acceptability. However, the evaluation activities clearly presented additional work for LAs. We are incredibly grateful to all of them for their continued collaboration in delivering the evaluation and their support in building young people's trust in the evaluation and data collection protocols.

Throughout all stages, we worked collaboratively with the central Your Choice programme delivery team and the VRU. We are indebted to them for their tireless efforts in supporting the evaluation and communicating its importance to LAs and staff. Their expertise helped us ensure the evaluation was designed with LAs, managers and practitioners in mind. Clearly, as experienced evaluators, we are committed and well accustomed to having an independent and impartial view of the programmes we evaluate.

Participant selection

Identification of teams

LAs identified teams to participate in the trial among those involved in supporting the target group of young people aged 11–18 (inclusive) at medium to high risk of contextual harm (the young people assessed by their practitioner to be at risk of committing acts of violence or to be vulnerable to being a victim of violence outside their families) with an interest in training in and delivering Your Choice.

LAs were asked to name at least two teams seeking training before the pilot started. In the transition period between the pilot and efficacy trials, LAs were asked to state whether the teams that had participated in the pilot wanted to carry on in the trial and/or whether they had additional eligible teams they could put forward for the trial.

The names and services of these teams were submitted to the evaluation team, which carried out the randomisation of teams into either the treatment or control group during the pilot and efficacy phases. This included teams that had served as control teams during the pilot phases in LAs that had at least three teams in the efficacy trial (so that there would always be at least one treatment and one control team in each LA). Details of the randomisation procedure can be found in the Randomisation section below.

In both the pilot and efficacy phases, LAs participating in the study signed a grant agreement with the VRU, including minimum requirements attached to their participation, such as their willingness for their teams to participate in the randomisation, to share data about participants' background information and compliance with the study, to facilitate survey data collection, and to deliver Your Choice. In the efficacy trial, the grant agreement also included the target number of young people the LA was supposed to recruit.

Participating LAs

The teams involved in the full evaluation (across the internal pilot and efficacy study) were from 31 LAs. Thirty of the 31 LAs were involved in the efficacy phase of the trial. One LA recruited participants during the pilot but could not participate in the efficacy trial.

Identification of participants

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

a) Age 11–17 (inclusive) years old at the time of recruitment (though they could turn 18 during the study).
b) Referred to Adolescent Safeguarding Services and assessed as medium to high risk of harm outside of the home. This risk rating was verified through acceptance onto the local agency multi-agency panel with the same risk thresholds or through local quality assurance processes.

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

Number of participants

The target number of participants was determined via our power calculations. See the section below for more details.

Outcome measures

The baseline and outcome measures used in this trial are described in Table 4. Baseline measures were gathered shortly after recruitment in week 1, using instruments from the baseline surveys of young people and practitioners. Outcome measures were assessed at endline, with the aim of doing so in week 20 after recruitment, using the same instruments as in the endline surveys of young people and practitioners. Both baseline and endline surveys of young people were completed during a session between the young person and the practitioner. Unless the young person needed help filling out the survey, the practitioner handed over their tablet or computer to the young person for them to fill out the survey online. The surveys were built with a function that reads the questions out loud in a young person's voice to reduce dependency on the practitioner being involved in the completion of the survey. In rare cases (e.g. young people with special educational needs), the practitioner may have needed to read and help the young person fill out the survey.

Baseline measures

Baseline measures include measures of internalising problems (emotional problems and peer problems), externalising problems (conduct problems and hyperactivity), prosocial behaviour, self-reported and practitioner-reported perceptions of young people's safety, social connectedness, and prosocial identity. All were measured as part of the baseline survey of participants and practitioners. These surveys were supposed to be administered shortly after recruitment, though sometimes it took longer to enable the young person and practitioner to establish a relationship first. The instruments are the same as those used in the endline surveys for primary and secondary outcomes, described below.

Primary outcome

The primary outcome is an indicator for whether the young person scores in the high or very high range of conduct problems measured by the SDQ (Goodman et al., 1997) using the fourfold categorisation provided by the SDQ developers. This outcome was measured for all participants as part of the young person endline survey, which was aimed to be taken at week 20 after recruitment.

The association between the SDQ conduct problems subscale and disruptive behaviour, including violent and non-violent delinquency, has been demonstrated in the existing literature (e.g., Spaan et al., 2023; and references therein). Relative to actual measures of criminal and violent activity, the SDQ conduct problem scale has three advantages. First, information on this outcome is readily available at the end of the participation period, while criminal activity takes time to (gradually) build up. Hence, it is favoured in cases when there is urgency in learning about the impact of the intervention. Second, impacts may also be more visible on this measure than on criminal activity in the medium run, given the low frequency of crime and the fact that conduct problems are likely at the forefront of the causal chain of effects of the intervention. In a setting where the size of the experiment may compromise what can be identified, it is crucial to identify a primary outcome that promises that impacts can be detected. Third, it is a more adequate measure to capture effects on violent behaviour and on vulnerability to being a victim of violence. Vulnerable youth is a target group of Your Choice.

Secondary outcomes

Secondary outcomes capture key mechanisms specified in the Your Choice logic model, including young people's emotional self-regulation, wellbeing, internalising and externalising behaviours, prosocial identity and behaviour, social connectedness, and perceived safety. These measures provide insight into whether the intervention influences intermediary outcomes that may, in turn, affect risks of violent behaviours. Table 4 above summarises each secondary outcome, its measurement instrument and timing. A further pre-specified secondary outcome (arrests within 16 months of recruitment, measured using the PNC dataset) will be analysed and reported separately when the administrative data become available.

Sample size

The sample size was determined primarily by power considerations, although with limited ability to adjust the number of participating teams, their caseloads and the desired duration of the implementation phase. We ran power calculations to determine the Minimum Detectable Effect Size in a sample whose size and structure (i.e. number of LAs, number of teams per LA and number of young people per team) we predicted based on information we collected from LAs about their recruitment expectations.

These power calculations were run under various assumptions about the intra-cluster correlation (ICC), the average likelihood of the primary outcome in the control group (informed by the pilot data) and the level of attrition from randomisation to sample analysis. Under the assumptions described in the last version of the protocol (ICC of 0.09 and mean outcome in the control group of 0.6) and an attrition rate of 30%, the power calculations suggested we needed a sample of 1,563 young people across 132 teams to detect a minimum effect size equal to a 22% reduction in the likelihood of young children exhibiting high to very high conduct problems. Under the assumptions of a mean outcome in the control group of 0.6, this 22% reduction was computed to be equivalent to a Cohen's d of 0.27.[1] We ran these power calculations using simulations in Stata, as described in the evaluation protocol and statistical analysis plan. As discussed in the evaluation protocol and statistical analysis plan, other CBT interventions achieve bigger impacts, so this study is considered well-powered because it is meaningfully sized, but impacts smaller than 22% could be undetected.

Randomisation

Randomisation was performed at the team level within each LA (stratum). The IFS team generated the random allocation using code written in Stata. Most teams involved in the efficacy trial were randomised in May 2023, ahead of recruitment in the efficacy phase starting in July 2023. A few LAs did not have their teams ready at that time, and the evaluator randomised their teams subsequently.

The randomisation of teams is not sufficient to guarantee that the assignment of young people (the relevant unit of observation) to treatment is random. For that, it is also required that the assignment of young people to teams is independent of the characteristics of young people and of how much they may benefit from treatment. The RCT design was drawn under the expectation that the assignment of young people to teams

[1] We calculated the Cohen's d as the ratio of the impact of Your Choice on the probability of a young person reporting high to very high conduct problems over the standard deviation of this probability in the control group.

was based on team availability at the time of referral in a system that works at capacity. The one exception was for young people returning to LA services after a brief interruption, who would be assigned to the same team that previously worked with them (prior to Your Choice). Both rules ensured that the assignment of young people to teams was independent of the treatment status of teams and hence as good as random: in the default case, because the time of referral is not planned based on team availability; for returning cases, because the assignment of the young person to teams precedes Your Choice and the assignment of teams to treatment is randomised and hence is not based on the young people assigned to them. If these assignment rules failed to hold, for instance, if young people with more serious difficulties were prioritised for teams delivering Your Choice, randomisation would be violated.

One additional necessary condition to guarantee the balance between treatment arms is that the recruitment of participants is independent of treatment assignment. Young people were recruited to participate in the trial *after* they were assigned to teams (and hence to treatment). Any systematic differences in recruitment across groups could, therefore, invalidate randomisation. To minimise the risk of selective recruitment, LAs were instructed not to disclose to the young people which type of support (Your Choice or BAU) they would be receiving until the young person had consented and filled out the baseline questionnaire to participate in the study. Naturally, the practitioners, who recruited young people in the study, were not blind to young people's allocation since they knew whether they had been trained in Your Choice and belonged to a Your Choice team.

Violations of the assignment rule based on capacity or of the balanced recruitment condition would amount to non-compliance and lead to selective enrolment. We tested for observed differences across groups to provide suggestive evidence of whether randomisation at the young person level holds. This is further discussed in the Analysis in the presence of non-compliance section below.

Qualitative data collectors from the AFC team were not blind to the random allocation, given that they purposely wanted to interview practitioners from both types of teams. Quantitative data was collected via online questionnaires filled out by the young people and the practitioner. At baseline, young people should still have been blind to their allocation at baseline survey completion (although there is no way to ascertain that this was the case in practice). At endline, young people were not blind, given that they knew whether they had received Your Choice or not.

Statistical analysis

We describe here the methods used for the statistical analysis as set out in the published Statistical Analysis Plan.

Imbalance at baseline

To test for imbalance between the treated and control groups, we report summary statistics of baseline characteristics of study participants in the control and treated group and test for statistical differences between the two. We report the unadjusted difference in means between the two groups, the adjusted difference in means (controlling for LA fixed effects) and the p-value of a t-test of the null hypothesis that this adjusted difference is equal to 0. These baseline characteristics include the characteristics collected in the workbooks (demographic characteristics and information about the need for support and the service in which the child receives support), as well as the baseline outcome collected in the baseline young people survey. We report this information for two different samples:

- Randomisation sample: the sample of young people recruited in the study
- Analysis sample: the sample of young people who contributed to the primary outcome analysis

Primary analysis

We estimate the Intention-to-Treat (ITT) effect of Your Choice on the primary outcome by estimating the following equation for young person i by ordinary least squares (OLS):

$$Y_{i1} = \beta_0 + \beta_1 D_i + \beta_2 X_i + \beta_3 Y_{i0} + LA_i + u_i \quad (1)$$

where:

- Y_{i1} is the primary outcome, i.e. an indicator that takes the value 1 if the young person reports high to very high levels of conduct problems and 0 otherwise
- D_i is an indicator which takes value 1 if the young person was allocated to a Your Choice and 0 if the young person was allocated to a BAU team
- X_i is a vector of baseline characteristics that are imbalanced between the treated and control group (we include any characteristic we find statistically significant at the 10% level in the imbalance table reported below)
- Y_{i0} is the value of the primary outcome at baseline
- LA_i is an indicator for the LA that supports the young person

Standard errors will be clustered at the LA level, following de Chaisemartin and Ramirez-Cuellar (2024). This allows for correlated errors within LA.

Secondary analysis

ITT analysis of secondary outcomes follows the same approach as for the primary outcome. We estimate the following equation by OLS:

$$Y_{i1} = \beta_0 + \beta_1 D_i + \beta_2 X_i + \beta_3 Y_{i0} + LA_i + u_i \quad (2)$$

where:

- Y_{i1} is the secondary outcome of interest
- D_i is an indicator which takes value 1 if the young person was allocated to a Your Choice and 0 if the young person was allocated to a BAU team
- X_i is a vector of baseline characteristics that are imbalanced between the treated and control group (we include any characteristic we find statistically significant at the 10% level in the imbalance table reported below)
- Y_{i0} is the value of the secondary outcome at baseline
- LA_i is an indicator for the LA that supports the young person

Standard errors will be clustered at the LA level, following de Chaisemartin and Ramirez-Cuellar (2024).

Given the large number of secondary outcomes, we will also report p-values that adjust for multiple hypotheses using the step-down procedure of Romano and Wolf (2016). The Romano–Wolf correction (asymptotically) controls the familywise error rate, that is, the probability of rejecting at least one true null hypothesis in a family of hypotheses under test. This correction is considerably more powerful than earlier multiple testing procedures, such as the Bonferroni and Holm corrections, as it accounts for the dependence

structure of the test statistics by resampling from the original data. To implement it, we use Stata's rwolf2 command, report unadjusted and adjusted *p*-values, and determine statistical significance of the results based on adjusted *p*-values below 0.05.

The trial was not powered to detect effects on secondary outcomes, with or without adjustments for multiple hypotheses. Their analysis is meant to provide suggestive evidence of the possible mechanisms underlying impacts, as described by the logic model.

Estimation of effect sizes

After reporting unadjusted and adjusted mean differences in primary and secondary outcomes, we also report effect sizes for all of them.

For binary outcomes (including the primary outcome), impact estimates will be reported as the proportional change in the likelihood of the outcome between the treatment and control groups. This is calculated as the difference in the probability of the outcome between the treatment and control groups divided by the probability of the outcome in the control group.

For continuous outcomes, impact estimates will be reported as effect sizes standardised using the outcome variance for the control group. This choice is robust to the possibility that the treatment changes the variance of the outcome, which we see as a likely event if, as expected, the impact of the treatment is heterogeneous.

For comparability with other trials, we also report in Appendix D effect sizes for both binary and continuous outcomes measured as Cohen's d, which we compute as the difference in means divided by the pooled standard deviation.

In all cases, we will show the 95% confidence interval and p-values for the estimated effect sizes. For secondary outcomes, we also report p-values adjusted for multiple hypothesis testing using Romano and Wolf (2016) using 500 bootstrap replications.

Subgroup analyses

We consider heterogeneous treatment effects by age, race/ethnicity, gender and practitioner risk assessment (when sample sizes allow this to be meaningfully done). Specifically, we run separate models and test for statistically significant differences in effects across the following subgroups:

- Age 11–15 vs age 16–18
- White vs Non-White and White vs Black vs South Asian
- Males vs females
- Low or medium risk vs high or very high risk, as measured by the practitioner's risk rating on the baseline practitioner survey[2]

[2] Note that the protocol specified that we would compare effects on children with medium vs high risk based on baseline risk assessment. This was under the assumption that practitioners would only assess young people with either a medium or a high risk rating, but they, in fact, also assessed young people as having a low risk rating. Breaking down the sample between young people with a low-risk rating vs a medium or high risk rating provides two more equally sized groups.

We report outcome means for each of the subgroups in the treatment and control groups, as well as the estimated ITT impacts of Your Choice on the primary outcome and the secondary outcomes in each of the subgroups. We also report the estimated difference in impacts between the relevant subgroups. The trial is not powered to detect differences in impact between any of these subgroups, so we consider this analysis exploratory rather than definitive.

Robustness checks

We run additional specifications to test the robustness of the results to altering the covariates included in the model. In expectation, due to randomisation of treatment, doing so should not change the point estimates of impact but may change the confidence intervals.

Specifically, we estimate the following specifications:

- A simple model, controlling only for the treatment assignment and strata fixed effect as covariates
- For binary outcomes, we estimate the ITT impacts of Your Choice using a logit model.[3]
  For all outcomes, we re-estimate the benchmark specification, this time, with robust standard errors (instead of standard errors clustered at the LA level).

In the protocol, we specified that we would also estimate, as part of robustness checks, a model controlling for covariates selected using a post-double selection LASSO procedure. This procedure uses LASSO to select variables that are most predictive of the treatment status (i.e. are most imbalanced between the control and treatment groups) and another LASSO to select variables that are most predictive of the outcome variables (to decrease the unexplained variance). We are not reporting these results in this version, as we have not been able to estimate such a procedure without a considerable loss of observations.

Missing data analysis

We examine the extent of missingness, the patterns of missingness and whether it correlates with treatment assignment. First, we specify the number of complete cases (i.e. those without any missing data) and attempt to establish the missingness mechanism (i.e. which variables in the data are predictive of non-response). To do the latter, we run a linear probability regression (accounting for strata fixed effects and clustering standard errors at the LA level) of an indicator that takes the value 1 if a variable is missing and 0 otherwise on the treatment indicator in the randomised sample of young people. This is done for outcome variables and covariates included in the primary and secondary outcome analysis.

We do not propose to impute missing outcome data for our main estimates. We follow YEF's guidance on missing data analyses and perform relevant sensitivity analyses if there is more than 10% missing data.

Analysis in the presence of non-compliance

Non-compliance in the Your Choice trial is defined at a number of levels, which have distinct implications for the interpretation of the ITT parameter identified via equations (1) and (2) above. Here we discuss three

[3] Our main ITT parameters are estimated using OLS (i.e. linear probability models for binary outcomes). When used for binary outcomes, the linear regression model is the least demanding model in terms of distributional assumptions and behaves well for probability away from the bounds 0 and 1. Its main drawback of potentially generating out-of-sample predictions outside the 0–1 range does not apply to this application, as we are not using the model for predictions. However, the probit or logit model behave better than the linear probability model at the tails.

conceptually different issues and their consequences for the interpretation of the ITT. We describe how we evidence compliance on each of them and the subsequent analysis, if any, that we perform to address them.

Non-compliance issue 1 (imbalance): the composition of the young people across the control and treated teams is not balanced, on average, due to non-adherence to the randomisation protocol and/or selective attrition

Description of compliance: within each LA, the assignment of young people to the trained and control teams is not selective based on the young person's characteristics or aspects of their case. This would be the case if LAs allocated young people to teams based on workload considerations in a system that works at capacity. Moreover, completion of surveys and the resulting presence of observations in the analytical sample are not selective based on treatment or unobserved characteristics of the young people.

Consequence of non-compliance: failure to adhere to non-selective allocation to teams could result in systematic imbalances in the composition of the treated and control groups, while selective failure to complete baseline and/or endline surveys would also contribute to imbalances in the composition of the groups. If this were the case, the unadjusted difference in outcome means of young people between the treated and control groups would not identify the causal impact of Your Choice on outcomes. The adjusted comparison would only identify it under the assumption that the treated and control groups did not differ in unobservable ways that affect outcomes once the covariates included in the model (baseline outcome and imbalanced characteristics at baseline) were controlled for.

Method to evidence non-compliance: to evidence this type of non-compliance, we will refer to the analysis of imbalance between the treated and control groups (mentioned above), as well as the analysis of attrition and missingness and the robustness checks that compare models with different control sets.

Subsequent analysis: we did not conduct additional analyses beyond the robustness checks and the analyses conducted to address selective attrition and missingness.

Non-compliance issue 2 (low dosage in the treated group): the Your Choice programme is not implemented with fidelity or only with partial fidelity

Description of compliance: implementing the Your Choice programme with fidelity requires that

- All practitioners in teams randomised to deliver Your Choice receive the full amount of training required by the programme designers.
- Young people in the Your Choice teams meet with their practitioners three times a week for 12 weeks (over the course of 12–18 weeks).
- Sessions delivered in the Your Choice group include CBT-informed elements of the Your Choice training programme.
- Trained practitioners meet at least monthly with their clinical supervisors to discuss progress and the cases assigned to them.

Consequence of non-compliance: if the Your Choice programme were not implemented with fidelity in the treated group, the ITT effect of being allocated to a treated group (as estimated via equation 1) would generally under-estimate the effect of receiving Your Choice.

Evidence of non-compliance: in the IPE section, we will provide descriptive evidence of the extent to which the Your Choice programme was implemented with fidelity, using:

- Data on the training of practitioners from the LA workbook to test whether all practitioners in Your Choice teams received Your Choice training (we do not have reliable data on the number of days of training they received to assess partial completion of training)
- Data on the number and content of sessions to test whether young people in the Your Choice group received the intended number of sessions and whether their sessions incorporated Your Choice content
- Data on the clinical supervision of practitioners from the LA workbook to test whether Your Choice practitioners received the amount of clinical supervision intended by the programme

This data will reveal both partial compliance, where the delivery of Your Choice sessions or clinical supervision was not as intensive as planned, and full non-participation, which amounts to some teams not being treated, young people assigned to treatment taking no Your Choice sessions or the complete absence of clinical supervision.

Analysis: in the presence of non-compliance or partial compliance, we further extend our analysis by using an instrumental variable (IV) approach to give an indication of the impacts on outcomes, a) of receiving Your Choice and b) of the intensity of treatment. To implement a) and b), we will use a Two Stage Least Squares approach, with group allocation as the IV for compliance. In a), we define compliance as a binary indicator that takes the value 1 if the young person receives any of the Your Choice programme and 0 otherwise. The assumption is that treatment assignment affects the likelihood of being treated by Your Choice but does not otherwise affect the outcome. In b), we define compliance as a continuous variable measuring the number of Your Choice sessions that the young person received. It is assumed that the intensity of treatment matters for the outcome and that treatment assignment increases the intensity of treatment but does not otherwise impact the outcome. The first stage models the compliance variable using the same explanatory variables as in the headline ITT analyses, along with the instrument. The second stage model uses predicted compliance in place of the group identifier variable in the ITT analyses specified above to generate Complier Average Causal Effect estimates.

Non-compliance issue 3 (contamination of the control group): young people in the control group receive the Your Choice programme or some elements of it

Description of compliance: young people supported in the BAU group receive the support that they would normally receive in the absence of the Your Choice programme being implemented in other teams. That is, while the support they receive may contain elements of CBT (if this were part of BAU support), they do not receive Your Choice sessions.

Consequence of non-compliance: if the control group is exposed to some dosage of Your Choice, for example if practitioners in control teams are trained in Your Choice or they learn about it via practitioners in trained teams, and if Your Choice has the impacts hypothesised in the logic model, then the ITT s estimated via equations (1) and (2) will underestimate the impact of being allocated to a team trained in Your Choice.

Evidence of non-compliance: in the IPE section, we will provide descriptive evidence of contamination of the control group using

- Data on the training of practitioners recorded in the LA workbook to test whether practitioners in BAU teams were trained in the Your Choice programme
- Data on the content of sessions conducted in the Your Choice and BAU groups to test whether young people in the control group received Your Choice sessions

Analysis: we will address this issue using the IV approach described above.

Estimation of ICC

Clusters are teams of practitioners, but given the discussion above about power, we will cluster standard errors at the LA level. We will calculate ICCs for both teams and LAs using the `estat icc' command in Stata.

Longitudinal analysis

The endline data was aimed to be collected at week 20 after the baseline data. This is when the primary and secondary outcomes we report on in this report were measured. For individuals for whom we have secured a UPN, we will apply for an extract of the linked National Pupil Database – Police National Computer data. This will be used to provide long-term follow-up for both outcomes related to education and criminal offences, which will be reported in a separate report in the future.

IPE

RQs for the IPE

The RQs of the IPE are:

IPE -RQ1. To what extent is Your Choice delivered as intended?
IPE -RQ2. To what extent is the delivery of Your Choice different from and similar to BAU?
IPE -RQ3. What are the barriers to and facilitators of delivery?
IPE -RQ4. What are young people's and practitioners' views and experiences of Your Choice (acceptability, impacts and mechanisms)?
IPE -RQ5. What are practitioners' views on the sustainability of Your Choice?

Research methods

To address the above RQs, we conducted a mixed-method IPE. We used a triangulation design convergence model, in which quantitative and qualitative data were collected and analysed separately and then interpreted together to provide complementary perspectives on the same topic.

Quantitative IPE data collection

The quantitative data involved the analysis of session survey forms, which were completed by practitioners after each session with young people in both the Your Choice and BAU arms. We also examined records of supervision sessions captured in the LA workbooks.

Qualitative IPE data collection

The qualitative data focused on the Your Choice group and involved interviews with young people, practitioners, SPoCs, leads, managers and Your Choice trainers. All interviews were predominantly conducted by phone or video call. All interviews were audio recorded and transcribed verbatim. To preserve confidentiality, we have not included identifiers for quotes from participants.

Interviews with young people who received the Your Choice intervention: we interviewed 22 young people about their experiences and opinions during the mid to late stages of receiving Your Choice (time 1). This includes their perceptions of the impact of the Your Choice programme on their lives, helpful and unhelpful factors, barriers and facilitators to engagement, and suggestions for improvement. We interviewed 12 of

these young people again approximately six months later (time 2). This included their perceptions of impact at this time point and their perspectives on their Your Choice sessions ending.

We monitored the diversity of the sample during recruitment and contacted practitioners to adjust recruitment processes when there were concerns that we were not including particular groups. For example, we worked with practitioners and the research YPAG to adjust how we were communicating with young people with special educational needs when inviting them to interviews and how we were conducting the interviews.

The young people were based in 13 LAs. They were aged 13 to 18 (mean [M] = 15.28, standard deviation [SD] = 1.41). Of the 22 young people interviewed, eight were female, 10 were male and gender data was missing for four. Age data was also missing for four young people. Ethnicity data was recorded for three of the young people as Asian or Asian British, two as Black or Black British, three as Mixed heritage, six as other and four as White. Ethnicity data was missing for four young people.

The research YPAG contributed to the development of the theme names. Interview length data for the time 1 interviews was not available at the time of publication. Interview lengths for the time 2 interviews ranged from 14 to 46 minutes (M = 27.58, SD = 9.89).

Interviews with Your Choice practitioners: we interviewed 20 Your Choice practitioners who were delivering the Your Choice programme. The practitioners were based in 16 LAs. The interviews ranged in length from 26 to 65 minutes (M = 47.65, SD = 8.68).

Interviews with SPoCs, leads and managers: we interviewed 12 SPoCs, leads and managers at services implementing the LYPS. The SPoCs, leads and managers were based in 10 LAs. The interviews ranged in length from 25 to 66 minutes (M = 42.88, SD = 11.88).

Interviews with Your Choice trainers: we interviewed nine Your Choice trainers who were based in six LAs. Interview length data for the trainer interviews was not available at the time of publication.

Analysis

Table 5 provides an overview of the IPE methods used in the evaluation.

Table 5. Implementation and process evaluation (IPE) methods overview

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed	Implementation/ logic model relevance
IPE	Survey	Session forms completed by the practitioner after each session of Your Choice or business-as-usual (BAU)	Descriptive statistics and inferential statistics (e.g. t-tests) of the session forms described in the impact section	IPE research questions 1 and 2	Intervention description, logic model

IPE	Administrative data	Supervision records completed by local authorities for practitioners in the Your Choice and BAU groups	Descriptive statistics	IPE research questions 1 and 2	Intervention description, logic model
IPE	Interview	22 young people (Your Choice arm)	Framework approach and thematic analysis	IPE research questions 1, 3 and 4	Intervention description, logic model
IPE	Interviews/ focus group	Your Choice trainers (n = 9), youth practitioners (n = 20) and single points of contact, leads and managers (n = 12)	Framework approach and thematic analysis	IPE research questions 1, 3, 4 and 5	Intervention description, logic model

Quantitative data from session forms and supervision records was used to answer IPE-RQs 1 and 2. Data was analysed using descriptive statistics and between-groups t-tests in SPSS.

Qualitative data from interviews was used to answer IPE-RQs 1, 3, 4 and 5. Data was analysed using the NVivo qualitative data analysis software package. We drew on the framework analysis approach (Ritchie and Spencer, 1994) to manage the data, categorising transcript extracts according to our RQs and according to which component of the logic model they addressed. We then drew on thematic analysis (Bruan and Clarke, 2006) to analyse the data organised within the framework, exploring themes across participants' experiences and perspectives. Different reliability processes are available for qualitative data than for quantitative data, and the research team adhered to quality standards for establishing the trustworthiness of the data (i.e., credibility, transferability, dependability and confirmability; Yardley, 2000).

Timeline

Table 6 outlines the timeline of activities involved in the efficacy trial and the organisation(s) leading on these activities.

Table 6. Timeline

Dates	Activity	Staff responsible / leading
31 May 2023	Randomisation of teams into the intervention	IFS

May–June 2023	Engagement of LAs and senior leadership in the efficacy phase	IFS, AFC, LIIA, VRU
5 June 2023	Submission of ethics application to UCL REC	IFS, AFC
June 2023	Development of grant agreements for LAs to participate in the efficacy phase	VRU with support from LIIA, IFS
June–July 2023	LAs train teams selected to deliver Your Choice as part of the efficacy trial and refresh training of previously trained teams partaking in the efficacy phase	LAs
June–July 2023	SPOCs and practitioners trained on evaluation requirements	IFS, AFC, LIIA, VRU
May–August 2023	Development of the data-sharing agreements supporting the evaluation	IFS, AFC, LIIA
May–August 2023	Development of the data collection interface	DXDigital with input from IFS, LAs, LIIA
August 2023–December 2024	Recruitment of young people and the delivery of Your Choice or BAU support	LAs
August 2023–December 2024	Collection of baseline data on efficacy phase participants	IFS, LAs
August 2023–March 2025	Collection of process data on efficacy phase participants	IFS, AFC, LAs
November 2023-March 2025	Collection of qualitative data	AFC
December 2023–March 2025	Collection of endline data on efficacy phase participants	IFS, LAs
January 2025	Decision to extend the recruitment period until the end of February 2025 for a select number of LAs	YEF with data and analysis provided by IFS
January–February 2025	Recruitment of children and young people in the extension of the study	LAs
April 2025–May 2025	Collection of endline data on efficacy phase participants recruited in the extension of the study	IFS, LAs
March–July 2025	Collection of cost data from LAs	IFS

June–December 2025	Preparing the final report on the efficacy phase	IFS, AFC
January 2026	Publication of the final report on the efficacy phase	YEF

IFS = Institute for Fiscal Studies, LA = local authority, AFC = Anna Freud Centre, YEF = Youth Endowment Fund, LIIA = London Innovation and Improvement Alliance, VRU = Violence Reduction Unit, UCL = University College London, REC = research ethics committee

Impact evaluation results

Participant flow, including losses and exclusions

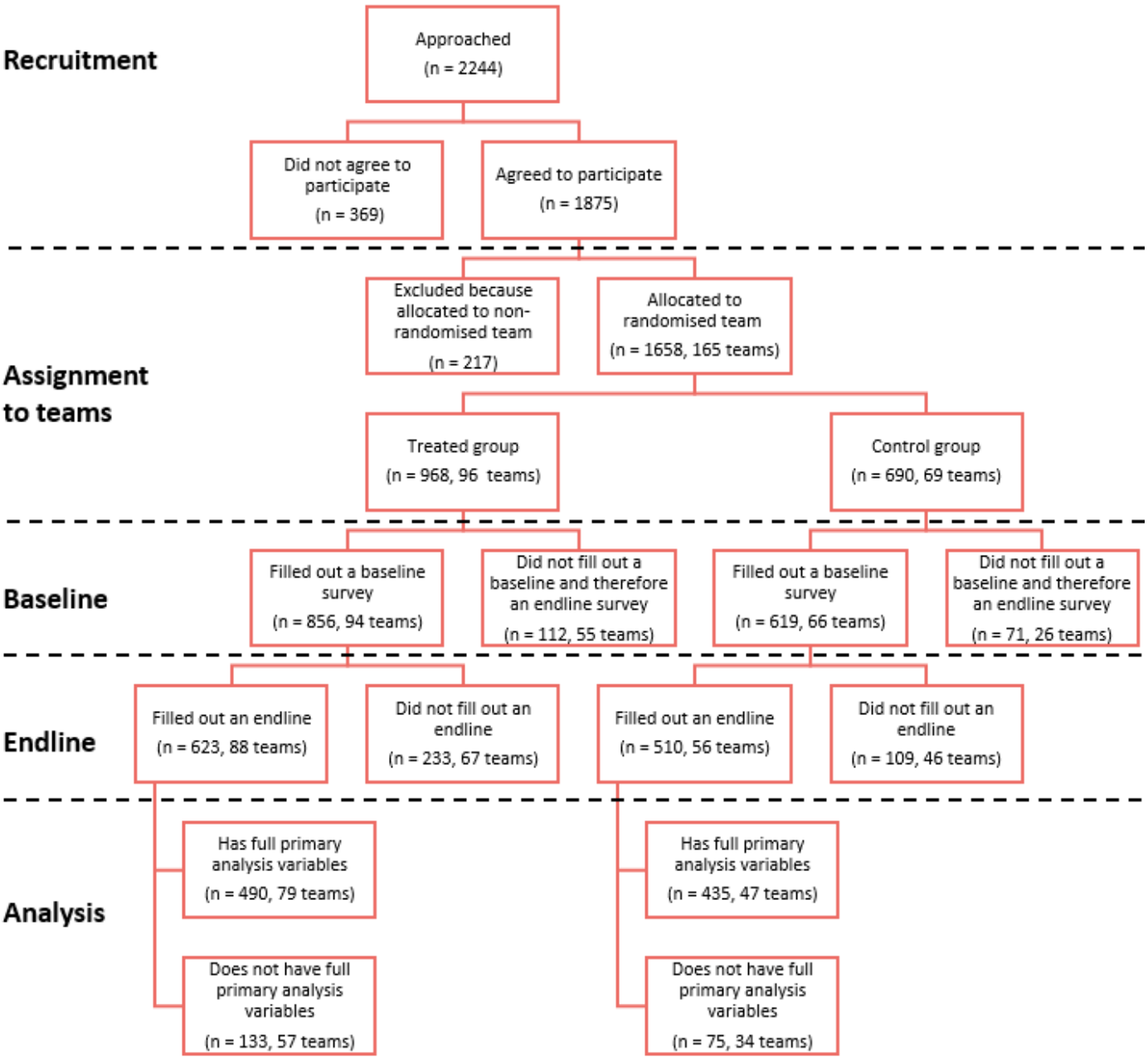
Figure 2 shows the participant flows for the 2,244 young people approached to be recruited across the pilot and efficacy trials and how we arrived at the primary analysis sample of 925 young people.

Among the 2,244 young people approached to participate in the study, 369 (16%) did not consent to do so. Among the 1,875 who did consent, 217 were excluded from the analysis because they were allocated to a non-randomised team in their LA. (In the Home Office pilot and the pilot trial, some teams were assigned to train in Your Choice. This is because either they were not randomised to be in the Home Office pilot or because they did not abide by the randomisation during the pilot trial. During the efficacy phase, some of these teams kept recruiting and collecting data on young children, but they were excluded from our analysis because of the lack of randomisation.)

The other 1,658 young people were allocated to one of the 165 teams participating in the study, which had been randomised to either train in and deliver Your Choice or to deliver BAU. Specifically, 968 young people (58% of this group of young people) were allocated to one of the 96 Your Choice teams, while the other 690 (42% of this group of young people) were allocated to one of the 69 BAU teams. Throughout the report, we refer to this sample of 1,658 young people as the randomised sample.[4]

[4] The imbalance in the number of young people across groups is primarily driven by the fact that there are more Your Choice teams than control teams. This is primarily because more Your Choice teams recruited in the Home Office and pilot stages were more likely to continue participating in the study than control teams were. Recruitment of young people per team was actually higher in control teams (14 on average) than in Your Choice teams (12 on average).

Figure 2. Participant flow diagram



Attrition

Once recruited, every young person in the randomised sample was asked to complete a baseline survey. As shown in Figure 2, 1,475 young people (88% of the randomised sample) completed a baseline survey – split between 856 young people in the treated group and 619 in the control group.

Twenty weeks after recruitment, young people in the study were asked to fill out a young person questionnaire to see whether they were still in the study. Note that only if a young person completed their baseline survey were they offered to complete an endline survey. Across the two groups, 1,133 young people (77% of the young people who filled out a baseline survey) also filled out an endline survey. This endline response rate (conditional on baseline completion) is slightly higher in the control group (82%) than in the treated group (73%). A few young people asked to withdraw from the study during the efficacy trial,

but there was no case of young people dropping out because the team that supported them withdrew from the study.

Individuals who contributed to the primary analysis sample must have non-missing data for all of the variables included in the primary analysis regression. This includes having non-missing data for the primary outcome (measured in the endline survey), the baseline primary outcome (measured in the baseline survey) and any other baseline covariates measured in the LA workbook or in the baseline young person or practitioner survey that show an imbalance between the treated and control groups. These data requirements were met by 490 young people in the treated group and 435 young people in the control group for a total sample of 925 used for the primary analysis. This is equivalent to 56% of the original 1,658 allocated to 165 randomised teams.

Table 7 summarises the number of young people in the randomised and in the primary analysis samples and reports the implied attrition rate for the trial, calculated as the ratio of the number of observations in the primary analysis sample to the number of young people in the randomised sample.

The implied attrition rate is 44% across the internal pilot and efficacy phases and across arms. The difference in attrition rates across experimental arms is substantially higher in the intervention group (50%) than in the control group (37%).

Separate analyses (unreported in this version) of participant flow and attrition in the pilot trial and the efficacy trial reveal that the attrition rate was a lot higher in the internal pilot (75%) than in the efficacy trial (40%).

Table 7. Attrition of children and young people from randomisation to the primary analysis sample

		Intervention	Control	Total
Number of participants	Randomised	968	690	1,658
	Analysed	490	435	925
Participant attrition (from randomisation to analysis)	Number	478	255	733
	Percentage	49.4%	37.0%	44.2%

Table 8 describes the ethnic and gender composition of the sample as we lose observations from randomisation to baseline survey completion to endline survey completion to primary analysis. Attrition across these different stages does not seem to be more systematically pronounced in a particular ethnic or gender group overall or within the treatment and control groups. We return to the issue of data missingness below and present further analyses of whether missing data is systematically related to treatment assignment.

Table 8. Proportion of children and young people from different ethnic and racial backgrounds and genders in different samples

	Sample of young people who have consented to be part of the study (randomised sample)	Sample of young people who have completed a baseline survey	Sample of young people who have completed a baseline survey and an endline survey	Sample of young people who contributed to the primary outcome analysis (analytical sample)

	(N=1,658)	(N=1,475)	(N=1,133)	(N=925)
Race and ethnicity				
Asian or Asian British	12%	12%	13%	14%
Treatment	8%	8%	9%	9%
Control	16%	17%	18%	18%
Arab	3%	3%	4%	4%
Treatment	3%	3%	3%	3%
Control	4%	4%	5%	5%
Black, Black British, Caribbean or African	22%	23%	22%	22%
Treatment	23%	24%	24%	24%
Control	21%	21%	19%	19%
Mixed or Multiple ethnic groups	24%	24%	25%	25%
Treatment	23%	22%	23%	24%
Control	25%	26%	27%	27%
White	20%	20%	19%	19%
Treatment	23%	22%	22%	22%
Control	16%	16%	16%	16%
Other	13%	13%	13%	13%
Treatment	15%	15%	15%	15%
Control	11%	9%	10%	10%
Prefer not to say	13%	12%	11%	4%
Treatment	14%	13%	12%	2%
Control	11%	11%	10%	5%
Gender				
Female	29%	29%	29%	33%
Treatment	25%	25%	25%	28%
Control	33%	34%	35%	39%
Male	60%	61%	62%	66%
Treatment	62%	63%	65%	71%
Control	57%	58%	58%	59%
Other/prefer not to say/missing	11%	11%	9%	2%
Treatment	13%	12%	11%	1%
Control	9%	9%	7%	2%

Participant characteristics

Table 9a examines a broader set of baseline characteristics of young people in the randomised sample and whether they are balanced across the treated and control groups. Specifically, we report the unadjusted mean difference between the two groups in standard deviations of the control group, the adjusted mean difference in standard deviations of the control group accounting for LA fixed effects (the randomisation strata), the p-value of a t-test that this adjusted difference is equal to 0, and the p-value for the same test, this time accounting for multiple hypothesis testing.

The unadjusted standard difference in characteristics provides a sense of the magnitude of the difference in the characteristics of young people in the control and treated teams across all LAs. A large majority of these differences are above 0.1 SD, which is the threshold used by the YEF to denote a high risk of imbalance.

In our context, however, treatment was randomised within LAs, which have different numbers and combinations of teams and serve populations with different needs. These compositional differences may bias estimates based on direct comparisons between young people in the treatment and control arms. Instead, the relevant statistic to test the validity of our design is to compare the characteristics of young people assigned to Your Choice and BAU teams within LAs, which amounts to testing the statistical significance of the adjusted standardised differences in the characteristics of young people.

Differences in young people's characteristics between the control and treated groups are much smaller within LAs than they are across LAs in most dimensions. Demographic characteristics are well balanced, though we note that the standardised difference in age and in the likelihood of having a special education need is between 0.05 and 0.1 SD, which is considered by the YEF as providing a moderate risk to the design, given that the likelihood of conduct problems and offending increases with age (within this group of young people) and that children with special educational needs are disproportionately represented in the Youth Justice System.

Within LAs, the primary needs that children and young people are supported for seem balanced between the treated and control teams. There are a few notable differences in the LA services represented in the control and treated teams. Specifically, young people in the treated group are more likely to be supported by a team sitting in the youth justice service of the LA than those in the control group. In contrast, young people in the control group are more likely to be supported by a team in Adolescent and Family Safeguarding than young people in the treated group. Differences in the supporting team mostly reflect variations across LAs in recruited young people and team composition. These differences become much less important and lose statistical significance once LA-level variation is netted out (see the column labelled 'Adjusted standardised difference' and the respective p-values). Interestingly, as shown in Table 9b, teams in the control group are more likely to sit in looked-after/children leaving care services, while teams in the treatment group are more likely to sit in youth justice services, but the proportion of teams in Adolescent and Family Safeguarding is similar. This discrepancy between individual-level and team-level imbalances could be due to teams in different services having different capacities and/or recruitment rates, but it could also signal some selective assignment of young people to the treated and control teams.

The imbalances in primary and secondary outcomes at baseline, which measure a set of behavioural and emotional difficulties, as well as practitioners' perceptions of the young person's risk and safety, would indicate that this may have taken place. Specifically, children and young people in the treated teams score higher on the conduct problems, hyperactivity and peer problems dimensions of the SDQ and lower on the prosocial behaviour dimension of the scale. These differences are large, between 0.2 and 0.4 SD. Furthermore, while there is a small difference in young people's perceptions of their safety between the treated and control teams of 0.096 SD, there is a much larger difference in practitioners' perceptions of the young people's safety in the two groups. On average, practitioners rate young people in the treated teams with a risk to safety score that is 0.32 SD higher than the score they give to young people in the control teams. On a risk rating from 1 to 4, they also rate them 0.28 SD higher than they rate young people in the control teams.

Together, this could suggest that LAs were more likely to allocate young people to Your Choice teams who had/who they perceived to have higher levels of risk and behavioural and emotional difficulties. If this were the case, it would violate the assumption underpinning the validity of the empirical design that the allocation of young people to teams is as good as random because it was primarily based on capacity constraints. Causal inference of the impact of being allocated to a Your Choice team on key outcomes will therefore rely on the assumption that any pre-existing differences in the characteristics of young people that predict the outcomes of interest are accounted for via the set of variables that we control for in the analysis.

As specified in the protocol, in addition to LA fixed effects and the outcome at baseline, the variables that we control for in the analysis include the characteristics of the young person or the supporting team that show imbalances and are expected to be important predictors of the outcome. All the variables collected at baseline were collected for their potential to predict the outcome, so we further restrict the set of variables we control for (in addition to the baseline outcome) by looking at the statistical significance of the adjusted standardised difference. We focus on the p-values adjusted for multiple hypothesis testing because the baseline variables all correlate with each other. As the p-values in the last column of the table show, there are four variables with a p-value below 0.05: an indicator for the child having special education needs, baseline prosocial behaviours score, practitioner risk rating and practitioners' perception of risk to the young person's safety. These four variables are the ones that we include as controls in our preferred specification for primary and secondary outcome ITT analysis, and we will perform a host of robustness analyses to strengthen our confidence that the ITT specification is likely to identify the causal effect of a young person being assigned to Your Choice on key outcomes.

Table 9a. Baseline characteristics of children and young people in treated and control groups in the randomised sample

Participant-level data	Control group		Treatment group		Unadjusted standardised differences	Adjusted standardised difference	Adjusted standardised difference p-value	Adjusted standardised difference stepdown p-value
	N	Mean (SD)	N	Mean (SD)				
Background characteristics								
Female	690	0.335	968	0.253	−0.173	−0.037	0.389	0.990
Age 16–17	655	0.565	878	0.440	−0.252	−0.080	0.093	0.210
Asian or Asian British	655	0.163	878	0.083	−0.217	−0.038	0.119	0.259
Arab	655	0.038	878	0.032	−0.033	0.004	0.668	0.990
Black or Black British	655	0.211	878	0.230	0.047	0.010	0.769	0.990
Mixed Heritage	655	0.255	878	0.230	−0.057	−0.005	0.885	0.998
White	655	0.160	878	0.227	0.181	0.002	0.958	0.998
Other	655	0.107	878	0.149	0.137	0.028	0.132	0.273
Prefer not to say /missing	690	0.113	968	0.137	0.077	0.040	0.050	0.090
Special educational needs	638	0.133	843	0.246	0.330	0.077	0.014	0.016
Disability	639	0.232	854	0.326	0.222	0.054	0.254	0.635
Looked after	612	0.134	816	0.161	0.078	−0.008	0.855	0.998

Involved with other council service	208	0.389	533	0.452	0.128	0.034	0.602	0.990
Most relevant primary need								
Abuse or neglect	639	0.049	844	0.083	0.160	0.011	0.608	0.990
Family in acute stress	639	0.059	844	0.076	0.069	−0.012	0.530	0.990
Family dysfunction	639	0.081	844	0.118	0.136	0.036	0.161	0.329
Socially unacceptable behaviour	639	0.380	844	0.424	0.090	0.005	0.912	0.998
Cases other than children in need	639	0.218	844	0.012	−0.498	−0.098	0.117	0.248
Not stated	639	0.125	844	0.147	0.066	0.036	0.174	0.363
Supporting local authority service								
Children looked after/leaving care	690	0.146	968	0.102	−0.125	−0.085	0.034	0.054
Schools/social workers in schools	690	0.088	968	0.094	0.020	−0.008	0.911	0.998
Early help	690	0.035	968	0.061	0.143	−0.019	0.527	0.990
Youth justice service	690	0.099	968	0.369	0.906	0.199	0.068	0.128
Adolescent and Family Safeguarding	690	0.632	968	0.373	−0.537	−0.088	0.410	0.916
Main activity								
School/college	619	0.803	855	0.685	−0.295	−0.066	0.200	0.461
Work for pay	619	0.065	855	0.034	−0.125	−0.018	0.257	0.635
Training	619	0.031	855	0.047	0.093	0.008	0.514	0.990
Other	619	0.141	855	0.240	0.285	0.069	0.160	0.327
Primary and secondary outcomes								
Conduct problems, high/very high range	598	0.261	811	0.353	0.209	0.052	0.183	0.389
Conduct problems score	598	3.110	811	3.702	0.279	0.396	0.039	0.068
		2.120		2.250				
Hyperactivity, high/very high range	600	0.315	811	0.386	0.153	0.041	0.383	0.896
Hyperactivity score	600	5.050	811	5.613	0.211	0.355	0.125	0.261
		2.669		2.613				
Emotional problems, high/very high range	597	0.203	809	0.155	−0.120	−0.024	0.471	0.964

Emotional problems score	597	3.211	809	3.091	−0.050	−0.048	0.823	0.996
		2.383		2.340				
Peer problems, high/very high range	602	0.309	806	0.344	0.075	0.023	0.510	0.988
Peer problems score	602	2.748	806	2.965	0.121	0.226	0.151	0.309
		1.800		1.865				
Prosocial behaviour, low/very low range	596	0.185	806	0.253	0.177	0.053	0.062	0.122
Prosocial behaviours score	596	7.242	806	6.836	−0.212	−0.313	0.022	0.026
		1.916		2.037				
Perceived risk to safety (self-report)	600	1.715	818	1.883	0.216	0.096	0.096	0.212
		0.779		0.859				
Perceived risk to safety (practitioner report)	607	2.408	866	2.793	0.453	0.329	0.003	0.004
		0.851		0.845				
Risk rating (1–4) (practitioner report)	606	1.693	863	2.029	0.526	0.282	0.016	0.016
		0.639		0.695				
Social connectedness score	606	3.706	827	3.625	−0.106	−0.041	0.553	0.990
		0.738		0.749				
Prosocial Identity score	534	2.837	728	2.665	-0.258	-0.100	0.042	0.072
		0.670		0.684				

Note: The table reports different statistics about different baseline characteristics of the children and young people included in the randomised sample (i.e., the sample that includes young people who consented to being part of the study and who were randomised to a team). The sample sizes indicated in columns 2 and 4 vary across variables because the young people did not always complete all of the questions on the baseline questionnaires, nor did the LA always complete all the data fields on the workbooks. In columns 3 and 5, we report the means of these variables in the control and treated samples, respectively. In column 6, we report the difference in mean between the two groups. In column 7, we report the difference in mean after controlling for LA fixed effects. In column 8, we report the p-value associated with a t-test of the null hypothesis that the adjusted difference is equal to 0. In column 9, we report the p-value associated with the same time, this time adjusting for multiple hypothesis testing across all characteristics. For continuous outcome variables, numbers in line below the mean report standard deviations.

SD = standard deviation

Table 9b. Characteristics of the control and treated teams included in the randomised sample

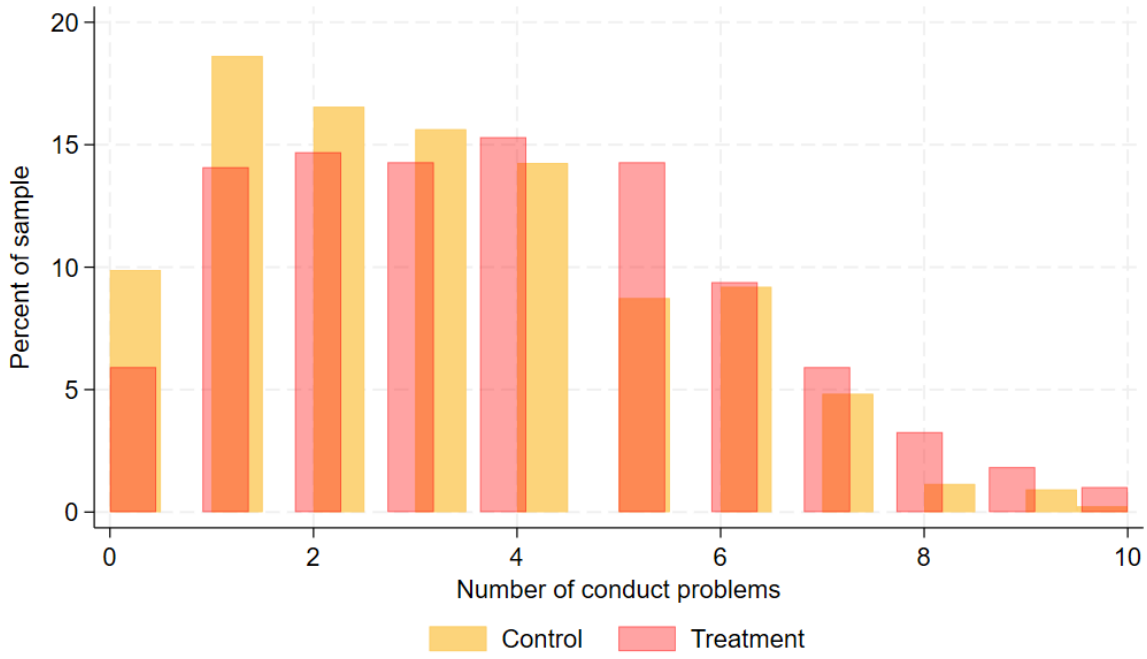
Team-level data	Control group		Treatment group		Unadjusted standardised differences	Adjusted standardised difference	Adjusted standardised difference p-value
	N	Mean (SD)	N	Mean (SD)			
Children looked after/leaving care	69	31.9%	96	17.6%	−14.2%	−13.1%	0.029
Schools/social workers in schools	69	5.8%	96	10.4%	4.6%	1.0%	0.714
Early help	69	14.5%	96	10.4%	−4.1%	−2.9%	0.398
Youth justice service	69	17.4%	96	27.1%	9.7%	11.7%	0.070
Adolescent and Family Safeguarding	69	30.4%	96	34.4%	3.9%	3.3%	0.584

Note: The table reports similar information as Table 9a, this time for characteristics of the teams included in the randomised sample.

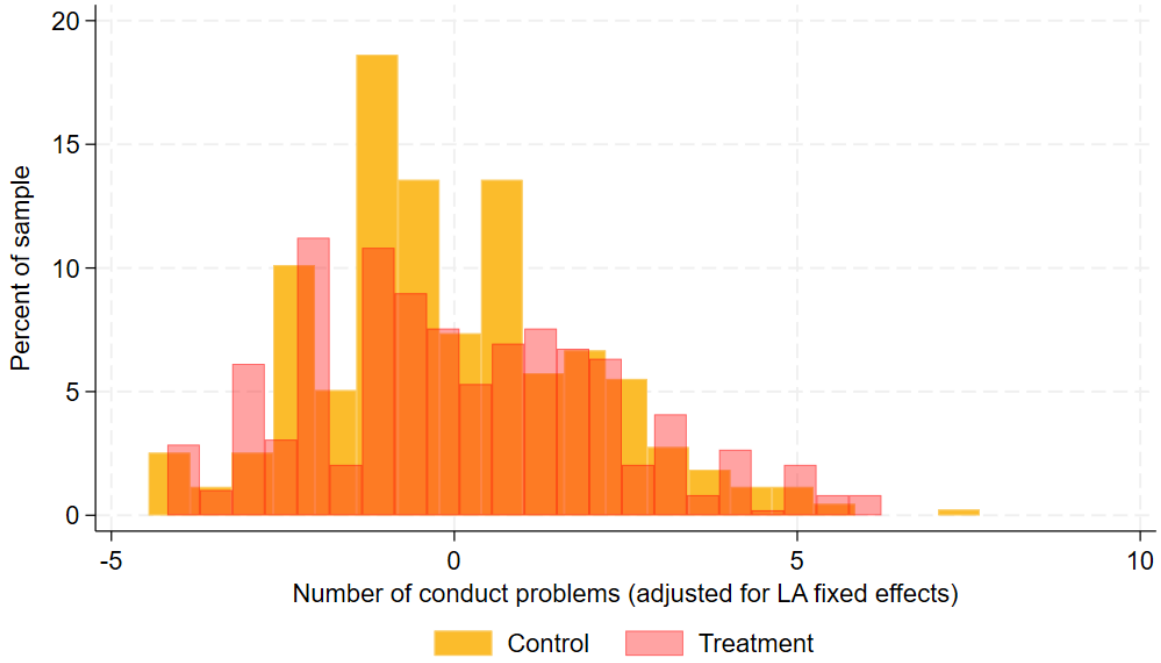
SD = standard deviation

Interestingly, Table 9a shows smaller differences at baseline between treated and control children's likelihood of being in the high/very high range of behavioural and emotional problems, as measured by the SDQ, than differences in the overall score, which ranges from 0 to 10. Figure 3 shows the full distribution of scores on the conduct problem scale for the control group (in grey), with that of the treatment group (in green). The graph on the left shows the raw distributions. The one on the right shows the distributions after controlling for LA fixed effects. The raw distribution for the treatment group is shifted to the right of the distribution for the control group, suggesting that children in the control group have lower levels of conduct problems across the whole distribution. Within LAs, these differences are a lot more muted (right graph), but we still see a shift in the whole of the control distribution to the left of the treated distribution.

Figure 3. Distribution of conduct problems at baseline, by treatment condition



a) Distribution of the number of conduct problems, by treatment group (N = 925)



b) Distribution of residualised number of conduct problems after netting out local authority (LA) differences, by treatment group (N = 925)

Tables 10a and 10b replicate this balance analysis, this time with the primary analysis sample. The broad differences in baseline characteristics between young people in the control and treated groups are similar in the primary analysis sample as in the randomised sample. While we provide further analysis to determine whether attrition is systematically related to treatment, the statistics reported in Table 10 already suggest that this is unlikely. Specifically, if attrition were selective in different ways among the treated and control groups, we would expect differences in baseline characteristics to show up more systematically in the primary analysis sample – a pattern that we do not observe. This conclusion is also in line with Table 8, which showed little sign of systematic attrition based on ethnic and gender characteristics.

Table 10a. Baseline characteristics of the treated and control groups in the analysis sample

Participant-level data	Control group		Treatment group		Unadjusted standardised differences	Adjusted standardised difference	Adjusted standardised difference p-value	Adjusted standardised difference stepdown p-value
	N	Mean (SD)	N	Mean (SD)				
Background characteristics								
Female	435	0.389	490	0.278	−0.227	−0.085	0.179	0.701
Age 16–17	435	0.568	490	0.398	−0.342	−0.093	0.109	0.475
Asian or Asian British	435	0.184	490	0.094	−0.232	−0.031	0.347	0.944
Arab	435	0.046	490	0.031	−0.073	−0.002	0.843	1.000
Black or Black British	435	0.193	490	0.241	0.121	0.036	0.261	0.852
Mixed heritage	435	0.271	490	0.239	−0.073	−0.028	0.468	0.958
White	435	0.159	490	0.220	0.169	−0.021	0.656	0.990
Other	435	0.097	490	0.153	0.191	0.042	0.155	0.639
Prefer not to say	435	0.051	490	0.022	−0.128	0.003	0.872	1.000

Special educational needs	435	0.117	490	0.249	0.409	0.080	0.106	0.475
Disability	435	0.221	490	0.345	0.299	0.048	0.515	0.960
Looked after	414	0.116	476	0.141	0.077	−0.019	414	0.998
Involved with other council services	136	0.375	316	0.465	0.186	−0.014	0.866	1.000
Most relevant primary need								
Abuse or neglect	435	0.046	485	0.091	0.213	0.029	0.251	0.852
Family in acute stress	435	0.048	485	0.074	0.121	−0.016	0.482	0.958
Family dysfunction	435	0.064	485	0.115	0.208	0.046	0.178	0.695
Socially unacceptable behaviour	435	0.386	485	0.406	0.041	−0.011	0.833	1.000
Cases other than children in need	435	0.290	485	0.016	−0.602	−0.123	0.143	0.593
Not stated	435	0.099	485	0.142	0.145	0.023	0.396	0.948
Supporting local authority service								
Children looked after/leaving care	435	0.099	490	0.088	−0.037	−0.058	0.219	0.762
Schools/social workers in schools	435	0.099	490	0.114	0.052	−0.050	0.412	0.944
Early help	435	0.016	490	0.049	0.261	−0.011	0.528	0.960
Youth justice service	435	0.051	490	0.363	1.425	0.243	0.072	0.329
Adolescent and Family Safeguarding	435	0.736	490	0.392	−0.779	−0.120	0.383	0.944
Main activity								
School/college	435	0.864	490	0.712	−0.444	−0.105	0.042	0.164
Work for pay	435	0.076	490	0.035	−0.155	−0.029	0.169	0.673
Training	435	0.028	490	0.049	0.130	0.013	0.418	0.948
Other	435	0.094	490	0.224	0.445	0.116	0.013	0.042
Panel E: Primary and secondary outcomes								
Conduct problems high/very high range	435	0.251	490	0.357	0.246	0.043	0.388	0.948
Conduct problems score	435	3.080	490	3.696	0.286	0.316	0.192	0.701
		2.151		2.294				
Hyperactivity high/very high range	433	0.326	484	0.388	0.134	0.018	0.768	1.000
Hyperactivity score	433	5.065	484	5.587	0.197	0.226	0.431	0.948
		2.646		2.595				
Emotional problems	432	0.213	483	0.151	−0.151	−0.061	0.110	0.475

high/very high range								
Emotional problems score	432	3.262	483	3.128	−0.056	−0.224	0.301	0.896
		2.398		2.344				
Peer problems high/very high range	433	0.279	484	0.351	0.160	0.059	0.209	0.749
Peer problems score	433	2.670	484	2.967	0.167	0.281	0.159	0.655
		1.785		1.841				
Prosocial behaviour low/very low range	435	0.184	490	0.259	0.194	0.047	0.104	0.475
Prosocial behaviours score	435	7.285	490	6.843	−0.234	−0.336	0.013	0.044
		1.893		2.103				
Perceived risk to safety (self-report)	432	1.671	484	1.853	0.233	0.077	0.335	0.944
		0.782		0.843				
Perceived risk to safety (practitioner report)	435	2.340	490	2.744	0.485	0.328	0.006	0.026
		0.833		0.835				
Risk rating (1–4) (practitioner report)	435	1.634	490	1.953	0.511	0.237	0.087	0.411
		0.624		0.695				
Social connectedness score	435	3.745	489	3.645	−0.137	−0.075	0.408	0.948
		0.731		0.759				
Prosocial identity score	418	2.853	457	2.703	−0.223	−0.061	0.367	0.944
		0.673		0.716				

Note: This table reports the same information as Table 9a but in the analytical sample, i.e. the sample of young people used for the intention-to-treat analysis of the primary outcome.

SD = standard deviation

Table 10b. Characteristics of the control and treated teams included in the analysis sample

Participant-level data	Control group		Treatment group		Unadjusted standardised differences	Adjusted standardised difference	Adjusted standardised difference p-value
	N	Mean (SD)	N	Mean (SD)			
Children looked after/leaving care	47	25.5%	79	17.7%	−7.8%	−7.1%	0.320
Schools/social workers in schools	47	8.5%	79	12.7%	4.1%	0.9%	0.825
Early help	47	10.6%	79	10.1%	−0.5%	−2.8%	0.538

Youth justice service	47	17.0%	79	26.6%	9.6%	10.3%	0.182
Adolescent and Family Safeguarding	47	38.3%	79	32.9%	−5.4%	−1.3%	0.819

Note: This table reports the same information as Table 9b but in the analytical sample, i.e. the sample of young people used for the intention-to-treat analysis of the primary outcome.

SD = standard deviation

Outcomes and analysis

Primary analysis

The primary outcome is an indicator for scoring high or very high in the SDQ conduct problems scale, measured at endline.

Table 11 reports the unadjusted means in the treated and control groups of the primary outcomes, as well as the difference in means between the two groups adjusted for LA fixed effects, the value of the primary outcome at baseline and the four baseline covariates that we found to be statistically significantly imbalanced at baseline (special educational needs, prosocial behaviour score, practitioners' risk rating and the perception of risk to the young person's safety).

This adjusted mean difference corresponds to the coefficient β_1 in equation (1). In this analysis, standard errors were clustered at the LA level, following Chaisemartin and Ramirez-Cuellar (2024). In the last column, we report the p-value of a test that the adjusted mean difference in the primary outcome is equal to 0.

The adjusted mean difference in the likelihood of a young person reporting a high or very high level of conduct problems between the treated and control groups is −0.008. This is very small and indistinguishable from 0 (p-value = 0.762).

Table 11. Unadjusted means of primary outcomes and adjusted mean difference between the treatment and control groups

Outcome	Unadjusted means				Adjusted mean difference		
	Treatment group		Control group				
	n	Mean	n	Mean	Total N	Estimate (standard error) [95% CI]	p-value
High or very high range of conduct problems	490	0.251	435	0.184	925	−0.008 (0.028) [−0.065, 0.048]	0.762

Note: From left to right, this table reports the sample size and means of the primary outcome in the intervention group and in the control group. In column 7, the table reports the mean difference in the primary outcome between the two groups after controlling for LA fixed effects. The standard error of this mean is reported in parentheses, and the 95% confidence interval (CI) is reported in brackets. The last column reports the p-value of a t-test of the null hypothesis that the adjusted mean difference is equal to 0. The sample used for this analysis is the analysis sample, N = 925, as indicated in column 6.

Secondary analysis

Like Table 11 for the primary outcome, Table 12 reports the *adjusted mean differences* between the intervention and control groups for each secondary outcome, expressed in the original units of

measurement (e.g. percentage points or raw scale scores). It is worth reiterating that the trial was not powered for the analysis of secondary outcomes, so the results discussed in this section are exploratory. Because of the risk of false positives when testing across so many correlated outcomes, we also report p-values adjusted for multiple hypothesis testing using the Romano–Wolf stepdown algorithm as per the protocol.

Starting with secondary outcomes measured using the SDQ, we report the adjusted mean difference for hyperactivity, emotional problems, peer problems (which are dimensions of internalising behaviours) and prosocial behaviours. As per the protocol, for each of these four dimensions, we look at both an indicator for young people reporting in the high to very high range of such problems and behaviours and the continuous score as outcomes. For prosocial behaviours, we look at an indicator for young people reporting in the low to very low range of prosocial behaviours and a continuous score, where a higher score means more prosocial behaviours. The adjusted mean differences are negative for hyperactivity, emotional problems, peer problems and low to very low prosocial behaviours, which would be in line with Your Choice improving outcomes. The adjusted mean difference for the continuous score of prosocial behaviours is negative, which is at odds with the logic model. However, none of these adjusted mean differences are statistically significant at conventional levels, and, therefore, we cannot be confident that they are different from zero.

Turning to perceptions of risk to the young person's safety, the analysis suggests that Your Choice could have reduced young people's own perceptions that their safety was at risk, which would also be in line with the logic model. However, practitioners' perceptions of the risk to the young people's safety increased, meaning that after working with young people, practitioners in the Your Choice group were more likely to perceive the young people as engaging in unsafe behaviours or being in unsafe environments than practitioners in the control group (conditional on all baseline differences in young people that we controlled for). This finding is not necessarily at odds with the programme's logic model. Indeed, it may also reflect that practitioners in the Your Choice group would have had more awareness of the young people's behaviours and environments because they worked more closely with young people. Importantly, none of these effects is statistically significant, which means that we cannot conclude that they are different from zero.

Finally, we find that Your Choice may have led to increases in social connectedness, prosocial identity, wellbeing and emotional self-regulation, although only the adjusted mean difference for social connectedness is statistically significant at the 5% level (after correcting for multiple hypothesis testing).

Table 12. Unadjusted means of secondary outcomes and adjusted mean difference between the treated and control groups

Outcome	Unadjusted means				Adjusted mean difference			
	Intervention group		Control group					
	n	Mean	n	Mean	Total N	Estimate (standard error) [95% CI]	p-value	p-value adjusted for MHT
Hyperactivity high/very high range	477	34.4%	427	28.1%	904	−0.039 (0.031) [−0.101, 0.024]	0.213	0.940
Hyperactivity score	477	5.34	427	4.738	904	−0.072 (0.184) [−0.449, 0.305]	0.698	0.531

Emotional problems high/very high range	473	17.1%	429	18.6%	902	−0.011 (0.024) [−0.060, 0.038]	0.642	0.866
Emotional problems score	473	3.089	429	3.212	902	−0.157 (0.186) [−0.538, 0.224]	0.407	0.940
Peer problems high/very high range	479	31.9%	429	32.9%	908	−0.073 (0.039) [−0.153, 0.006]	0.07	0.866
Peer problems score	479	2.823	429	2.697	908	−0.146 (0.168) [−0.489, 0.197]	0.392	0.148
Prosocial behaviours low/very low range	487	28.1%	434	22.4%	921	−0.001 (0.039) [−0.081, 0.079]	0.982	0.940
Prosocial behaviours score	487	6.805	434	7.217	921	−0.034 (0.167) [−0.375, 0.307]	0.84	0.980
Perceived risk to safety (self-report)	474	1.619	418	1.55	892	−0.094 (0.068) [−0.234, 0.046]	0.18	0.475
Perceived risk to safety (practitioner report)	460	2.204	394	1.77	854	0.092 (0.143) [−0.200, 0.384]	0.524	0.910
Social connectedness score	485	3.727	435	3.748	920	0.115** (0.044) [0.025, 0.205]	0.014	0.024
Prosocial identity score	449	3.613	416	3.696	865	0.040 (0.068) [−0.100, 0.179]	0.568	0.932
Mental wellbeing score	483	3.499	433	3.55	916	0.045 (0.060) [−0.077, 0.168]	0.453	0.878
Emotional self-regulation score	490	1.793	435	1.705	925	0.079 (0.061) [−0.047, 0.205]	0.208	0.531

Note: From left to right, for each secondary outcome, this table reports the sample size and means of the outcome in the intervention group and in the control group. In column 7, the table reports the mean difference in the outcome between the two groups after controlling for local authority fixed effects. The standard error of this mean is reported in parentheses, and the 95% confidence interval (CI) is reported in brackets. The second-to-last column reports the p-value of a t-test of the null hypothesis that this adjusted mean difference is equal to 0. The last column reports the same p-value, this time adjusted for multiple hypothesis testing. The sample used for this analysis varies across secondary outcomes because not all young people included in the primary analysis sample have non-missing secondary outcomes.

MHT = Multiple Hypothesis Testing

Effect sizes

Tables 13a and 13b translate the adjusted estimates for the primary outcome (reported in Table 11) and secondary outcomes (reported in Table 12) into *effect sizes* to show the relative magnitude of the effects in a standardised way – as proportionate changes for binary outcomes and standard deviation units of the

control group for continuous outcomes. Tables 13a and 13b, therefore, describe the same underlying results as Tables 11 and 12 but from different perspectives: Tables 11 and 12 show the raw adjusted differences, while Table 13 shows their practical significance on a common scale. We describe these results in turn, but readers should interpret them together rather than as separate findings. Note that Appendix D reports effect sizes measured as Cohen's d for all outcomes, whether they are binary or continuous.

Your Choice decreased the probability that young people reported conduct problems in the high to very high range relative to the control group mean by 4.6%. This effect size is small and is well below the effect size powered by the trial to detect and well below the impact of CBT interventions reported in the literature. In addition, the confidence interval for this effect size is very large, so we cannot rule out that Your Choice may have had a much larger negative or positive impact on this outcome.

Turning to secondary outcomes, we find suggestive evidence of larger reductions in the probability of young people reporting high to very high levels of hyperactivity (13.9%) or peer problems (22.3%) and in young people's perceptions of the risk to their safety (12.7% of a standard deviation). After adjusting for multiple hypothesis testing, however, none of these impacts can be concluded to be different from zero. Effect sizes for continuous scores show that Your Choice had statistically non-significant low impacts on reducing children's hyperactivity, emotional problems and peer problems and on improving prosocial identity. It had moderate impacts on increasing children's social connectedness, emotional self-regulation and how safe young people felt, and it had a moderate effect on reducing how safe practitioners felt young people were – although only the impact on social connectedness is statistically significant at the 5% level after adjusting for multiple hypothesis testing. It had no impact on children's prosocial behaviours

Table 13a. Effect sizes for the primary outcome

Outcome	Proportionate effects for binary outcomes Standardised effects for continuous outcomes		
	Estimate	[95% CI]	p-value
Proportionate change in the likelihood of reporting in the high to very high range of conduct problems relative to the control group mean	−4.6%	[−35.4%, 26.2%]	0.762

Note: This table reports effect sizes for the primary outcome. It is computed as the adjusted mean difference between the treated and control groups divided by the mean of the variable in the control group. Column 2 of this table reports the estimate of such an effect size. Columns 3 and 4 report the 95% confidence interval and p-value of a t-test, respectively, for the null hypothesis that this estimate is equal to 0.

CI = confidence interval

Table 13b. Effect sizes for secondary outcomes

Outcome	Proportionate effects for binary outcomes Standardised effects for continuous outcomes			
	Estimate	[95% CI]	p-value	p-value adjusted for MHT
Hyperactivity, high/very high range	−13.9%	[−0.363, 0.084]	0.213	0.940
Hyperactivity score	−0.027	[−0.165, 0.112]	0.698	0.531
Emotional problems, high/very high range	−6.0%	[−0.322, 0.202]	0.642	0.866
Emotional problems score	−0.065	[−0.223, 0.093]	0.407	0.940

Peer problems, high/very high range	−22.3%	[−0.465, 0.019]	0.070	0.866
Peer problems score	−0.076	[−0.257, 0.104]	0.392	0.148
Prosocial behaviours, low/very low range	−0. 4%	[−0.362, 0.354]	0.982	0.940
Prosocial behaviours score	−0.017	[−0.187, 0.153]	0.840	0.980
Perceived risk to safety (self-report)	−0.127	[−0.316, 0.062]	0.180	0.475
Perceived risk to safety (practitioner report)	0.107	[−0.232, 0.445]	0.524	0.910
Social connectedness score	0.152	[0.033, 0.271]	0.014	0.024
Prosocial identity score	0.044	[−0.111, 0.198]	0.568	0.932
Wellbeing score	0.059	[−0.099, 0.216]	0.453	0.878
Emotional self-regulation	0.156	[-0.092, 0.403]	0.208	0.531

Note: This table reports effect sizes for the secondary outcomes. These are computed differently, depending on whether the secondary outcome is a continuous or a binary variable. If the secondary outcome is a continuous score, the effect size is computed as the adjusted mean difference between the treated and control groups divided by the standard deviation of the variable in the control group. If the secondary outcome is a binary variable (i.e. variables indicating the high/very high range), the effect size is computed as the adjusted mean difference between the treated and control groups divided by the probability of the outcome in the control group. Column 2 of this table reports the estimate of such effect sizes. Columns 3 and 4 report the 95% confidence interval (CI) and p-value, respectively, of a t-test for the null hypothesis that this estimate is equal to 0. Column 5 reports p-values for the same variables, this time adjusted for multiple hypothesis testing across all secondary outcomes.

Subgroup analysis

Having reported effect sizes across the whole analysis sample, we now turn to examining the effects of Your Choice on the primary and secondary outcomes for key subgroups of interest. The tables in this section report the adjusted mean differences for each outcome in each subgroup, as well as the difference in effect between relevant subgroups. As mentioned above, none of the subgroup analyses are powered by the trial, so we treat this analysis with caution. Furthermore, for secondary outcomes, we present below the point estimate its standard error between parentheses and in italics p-values adjusted for multiple hypothesis testing below the coefficients in brackets due to the risk of false positives.

First, we examine whether the impacts of Your Choice vary by whether the young person's ethnicity is White, Black, or Asian or Asian British. The results reported in Table 14 show that the effect of Your Choice on young people's likelihood to report high to very high levels of conduct problems is negative for White and Asian young people but positive for Black young people. Note that these impacts are adjusted mean differences expressed in the original unit of measurement (as in Tables 11 and 12 for the whole sample). None of these coefficients is statistically different from zero, however, and the differences between the effects for these groups are also not statistically significant at the conventional 5% level – so no firm conclusion can be drawn about possibly heterogeneous impacts of Your Choice across young people of different racial and ethnic backgrounds.

Turning to the secondary outcomes, the results presented in Table 14 suggest that the effects of Your Choice on emotional and behavioural difficulties, captured by the SDQ, may have been more pronounced among White and Asian young people than among Black young people. Indeed, for White young people, the effect of Your Choice is to reduce peer relationship problems (whether measured as a continuous score or as an indicator of high to very high levels of peer problems) and increase levels of prosocial behaviours. The analysis also suggests that Asian young people may have seen reductions in other dimensions of emotional and behavioural problems, but the results for Black young people are not as consistent. In fact, most point estimates are positive for this group. On the other hand, we find that Your Choice may have improved self-regulation for the group of Black young people in the study (the point estimate is 0.219 and is statistically

significant at the 5% level). None of these effects is statistically significant once we adjust for multiple hypothesis testing.

Overall, while highly exploratory, this analysis suggests that Your Choice may have had heterogeneous effects across the groups of White, Black and Asian young people, with potentially stronger effects in the expected direction for White and Asian young people.

Table 14. Primary and secondary analysis, by the young person's race

Outcome	Effect among White CYPs	Effect among Black CYPs	Effect among Asian CYPs	Difference in effect between White and Black CYPs	Difference in effect between White and Asian CYPs	Difference in effect between Black and Asian CYPs
Primary outcome						
Conduct problems high/very high range	−0.025 (0.079)	0.075 (0.102)	−0.159 (0.109)	0.101 (0.125)	−0.133 (0.127)	−0.234 * (0.123)
Secondary outcomes						
Hyperactivity high/very high range	−0.118 * (0.058) *0.208*	0.040 (0.087) *0.986*	−0.066 (0.090) *0.958*	0.158* (0.083) *0.760*	0.052 (0.118) *0.204*	−0.106 (0.144) *0.096*
Hyperactivity score	−0.414 (0.261) *0.307*	0.393 (0.393) *0.808*	−1.131*** (0.295) *0.271*	0.807* (0.409) *0.655*	−0.717 (0.443) *0.992*	−1.525*** (0.423) *0.996*
Emotional problems high/very high range	0.029 (0.086) *0.836*	−0.070 (0.066) *0.719*	−0.168* (0.098) *0.860*	−0.100 (0.118) *0.603*	−0.197 (0.122) *0.323*	−0.097 (0.100) *0.429*
Emotional problems score	0.224 (0.434) *0.836*	−0.451 (0.385) *0.671*	−1.867** (0.827) *0.595*	−0.676 (0.570) *0.595*	−2.092** (0.857) *0.479*	−1.416 * (0.761) *0.679*
Peer problems high/very high range	−0.114 (0.113) *0.609*	0.134 (0.080) *0.339*	−0.158 (0.239) *0.958*	0.248 (0.152) *0.483*	−0.044 (0.277) *0.946*	−0.292 (0.283) *0.906*
Peer problems score	−0.885** (0.414) *0.194*	0.358 (0.400) *0.854*	−0.619 (0.677) *0.918*	1.243** (0.581) *0.064*	0.266 (0.786) *0.980*	−0.977 (0.887) *0.990*
Prosocial behaviours low/very low range	−0.123 (0.072) *0.339*	0.090 (0.096) *0.808*	0.086 (0.112) *0.958*	0.213* (0.115) *0.892*	0.209 (0.137) *0.946*	−0.004 (0.158) *0.996*
Prosocial behaviours score	0.731 (0.491) *0.367*	0.075 (0.389) *0.986*	−0.362 (0.438) *0.952*	−0.656 (0.582) *0.687*	−1.093* (0.623) *0.934*	−0.437 (0.521) *0.996*

Perceived risk to safety (self-report)	−0.201* (0.113) *0.329*	−0.017 (0.197) *0.986*	−0.085 (0.170) *0.958*	0.184 (0.234) *0.892*	0.116 (0.186) *0.992*	−0.068 (0.234) *0.996*
Perceived risk to safety (practitioner report)	−0.348 (0.304) *0.653*	0.433** (0.203) *0.246*	0.198 (0.162) *0.860*	0.781** (0.351) *0.036*	0.545* (0.310) *0.794*	−0.235 (0.163) *0.996*
Social connectedness score	0.114 (0.121) *0.749*	0.163 (0.135) *0.545*	0.294 (0.272) *0.860*	0.049 (0.223) *0.892*	0.180 (0.307) *0.946*	0.131 (0.286) *0.972*
Prosocial identity score	0.200 (0.171) *0.421*	0.000 (0.124) *0.986*	0.258* (0.140) *0.810*	−0.199 (0.191) *0.892*	0.059 (0.225) *0.934*	0.258 (0.165) *0.816*
Wellbeing score	0.120 (0.205) *0.816*	−0.053 (0.127) *0.986*	0.241 (0.298) *0.952*	−0.173 (0.262) *0.846*	0.122 (0.316) *0.946*	0.294 (0.323) *0.972*
Emotional self-regulation	−0.018 (0.114) *0.884*	0.219** (0.101) *0.170*	−0.132 (0.259) *0.958*	0.237 (0.160) *0.655*	−0.114 (0.260) *0.946*	−0.351 (0.328) *0.902*

Note: This table reports the estimate of the intention-to-treat impact of Your Choice on three different subsamples, defined by whether the young person is White or White British; Black, Black British, Caribbean or African; or Asian or Asian British. Figures in parentheses show standard errors of estimates. Asterisks (*, **, ***) signify statistical significance at 10%, 5% and 1%, respectively. In each cell, we report the point estimates, the standard error (in parentheses), and, in italics, the p-value of a test of the null hypothesis that the coefficient is zero, adjusting for multiple hypothesis testing across all secondary outcomes.

CYPs = children and young people

Table 15 reports the results of a similar analysis, this time considering differences by gender. Across all outcomes considered, we find little evidence that the effects of Your Choice may have been stronger for one group than the other.

Table 15. Primary and secondary analysis, by the young person's gender

Outcome	Impact among male CYPs	Impact among female CYPs	Difference in impact
Primary outcome			
Conduct problems, high/very high range	−0.005 (0.034)	0.009 (0.063)	0.014 (0.070)
Secondary outcomes			
Hyperactivity high/very high range	−0.028 (0.037) *0.804*	−0.026 (0.076) *0.990*	0.002 (0.079) *0.998*
Hyperactivity score	−0.062 (0.219) *0.980*	0.104 (0.387) *0.990*	0.166 (0.412) *0.970*
Emotional problems, high/very high range	−0.035 (0.031) *0.587*	0.053 (0.083) *0.980*	0.088 (0.101) *0.836*
Emotional problems score	−0.224 (0.197) *0.587*	0.176 (0.406) *0.986*	0.400 (0.468) *0.836*

Peer problems, high/very high range	−0.134*** (0.045) *0.008*	0.008 (0.081) *1.000*	0.141 (0.095) *0.417*
Peer problems score	-0.270 (0.221) *0.525*	0.097 (0.266) *0.986*	0.367 (0.365) *0.743*
Prosocial behaviours, low/very low range	0.035 (0.042) *0.804*	−0.103 (0.068) *0.601*	−0.137* (0.068) *0.150*
Prosocial behaviours score	−0.050 (0.206) *0.982*	0.177 (0.268) *0.986*	0.227 (0.311) *0.862*
Perceived risk to safety (self-report)	−0.042 (0.083) *0.958*	−0.264** (0.128) *0.309*	−0.222 (0.155) *0.417*
Perceived risk to safety (practitioner report)	0.157 (0.159) *0.683*	−0.068 (0.142) *0.986*	−0.226 (0.188) *0.625*
Social connectedness score	0.087 (0.054) *0.299*	0.147 (0.115) *0.651*	0.061 (0.136) *0.970*
Prosocial identity score	0.098 (0.092) *0.683*	−0.125 (0.106) *0.866*	−0.223 (0.149) *0.417*
Wellbeing score	−0.003 (0.073) *0.996*	−0.003 (0.134) *1.000*	−0.000 (0.160) *0.998*
Emotional self-regulation score	0.085 (0.075) *0.587*	0.125 (0.077) *0.425*	0.040 (0.106) *0.970*

Note: This table reports the estimate of the intention-to-treat impact of Your Choice on two different subsamples, defined by whether the young person is male or female (we excluded young people who preferred not to say). Figures in parentheses show standard errors of estimates. Asterisks (*, **, ***) signify statistical significance at 10%, 5% and 1%, respectively. In each cell, we report the point estimates, the standard error (in parentheses), and, in italics, the p-value of a test of the null hypothesis that the coefficient is zero, adjusting for multiple hypothesis testing across all secondary outcomes.

CYPs = children and young people

Table 16 reports the effect of Your Choice on young people who were less than 16 at recruitment and young people who were 16 and over. Again, there does not seem to be a systematic pattern of heterogeneity emerging from these results.

Table 16. Primary and secondary analysis, by the young person's age group

Outcome	Impact among CYPs who are less than 16	Impact among CYPs who are 16 and over	Difference in impact
Primary outcome			
Conduct problems, high/very high range	−0.031 (0.043)	0.001 (0.051)	0.032 (0.074)
Secondary outcomes			
Hyperactivity, high/very high range	−0.086** (0.040)	0.040 (0.063)	0.126 (0.089)

	0.122	*0.950*	*0.617*
Hyperactivity score	−0.155 (0.245) *0.920*	0.159 (0.272) *0.972*	0.314 (0.375) *0.968*
Emotional problems, high/very high range	−0.001 (0.028) *0.992*	−0.026 (0.049) *0.976*	−0.025 (0.056) *1.000*
Emotional problems score	−0.090 (0.196) *0.938*	−0.193 (0.299) *0.976*	−0.103 (0.291) *1.000*
Peer problems, high/very high range	−0.081* (0.044) *0.238*	−0.034 (0.064) *0.976*	0.047 (0.066) *0.982*
Peer problems score	−0.159 (0.206) *0.920*	−0.154 (0.250) *0.976*	0.005 (0.259) *1.000*
Prosocial behaviours, low/very low range	0.027 (0.048) *0.946*	−0.026 (0.057) *0.976*	−0.053 (0.070) *0.982*
Prosocial behaviours score	−0.075 (0.168) *0.948*	0.016 (0.281) *0.980*	0.092 (0.290) *1.000*
Perceived risk to safety (self-report)	−0.122 (0.101) *0.561*	−0.069 (0.091) *0.976*	0.053 (0.135) *1.000*
Perceived risk to safety (practitioner report)	0.007 (0.117) *0.992*	0.092 (0.235) *0.976*	0.085 (0.195) *1.000*
Social connectedness score	0.088* (0.048) *0.216*	0.082 (0.068) *0.824*	-0.007 (0.086) *1.000*
Prosocial identity score	0.096 (0.073) *0.623*	0.120 (0.102) *0.824*	0.024 (0.108) *1.000*
Wellbeing score	0.042 (0.066) *0.920*	0.031 (0.109) *0.976*	-0.011 (0.128) *1.000*
Emotional self-regulation	0.056 (0.065) *0.920*	0.075 (0.098) *0.952*	0.019 (0.104) *1.000*

Note: This table reports the estimate of the intention-to-treat impact of Your Choice on two different subsamples, defined by whether the young person was 11–15 or 16–17 at recruitment to the study. Figures in parentheses show standard errors of estimates. Asterisks (*, **, ***) signify statistical significance at 10%, 5% and 1%, respectively. In each cell, we report the point estimates, the standard error (in parentheses), and, in italics, the p-value of a test of the null hypothesis that the coefficient is zero, adjusting for multiple hypothesis testing across all secondary outcomes.

CYPs = children and young people

Finally, Table 17 reports the results of the primary and secondary analysis on the sample of young people rated by their practitioner as having a low or medium risk at baseline and on the sample of young people rated as having a high or very high risk. Overall, estimates suggest that the programme was more beneficial for young people at medium to high risk. Differences in effects are statistically significant and in the direction predicted by the theory of change for the primary outcome. Individual differences are also statistically significant and point in the predicted direction for a few of the secondary outcomes, including measures of

peer problems, prosocial behaviour, perceived risk to safety, social connectedness and prosocial identity. However, multiple hypothesis testing does not offer confidence in these findings, with p-values consistently above 0.1, except for the prosocial behaviour score.

Table 17. Primary and secondary analysis, by the young person's risk at baseline

Outcome	Effect among CYP with low risk	Effect among CYP with medium to high risk	Difference in effect
Primary outcome			
Conduct problems, high/very high range	0.116* (0.058)	−0.059 (0.043)	−0.175** (0.075)
Secondary outcomes			
Hyperactivity, high/very high range	−0.083* (0.043) *0.545*	−0.040 (0.038) *0.727*	0.043 (0.054) *0.818*
Hyperactivity score	−0.007 (0.213) *1.000*	−0.187 (0.248) *0.727*	−0.180 (0.330) *1.000*
Emotional problems, high/very high range	0.013 (0.038) *1.000*	−0.001 (0.027) *1.000*	−0.014 (0.045) *1.000*
Emotional problems score	−0.037 (0.334) *1.000*	−0.176 (0.176) *0.727*	−0.139 (0.328) *1.000*
Peer problems, high/very high range	0.014 (0.047) *1.000*	−0.115** (0.053) *0.182*	−0.129* (0.066) *0.273*
Peer problems score	0.288 (0.181) *0.727*	−0.247 (0.194) *0.545*	−0.535** (0.218) *0.273*
Prosocial behaviours, low/very low range	0.100 (0.081) *0.818*	−0.053 (0.052) *0.727*	−0.152 (0.093) *0.273*
Prosocial behaviours score	−0.779*** (0.236) *0.091*	0.233 (0.198) *0.727*	1.012*** (0.240) *0.091*
Perceived risk to safety (self-report)	0.008 (0.065) *1.000*	−0.156* (0.09) *0.273*	−0.164* (0.082) *0.273*
Perceived risk to safety (practitioner report)	−0.010 (0.122) *1.000*	0.033 (0.184) *1.000*	0.042 (0.228) *1.000*
Social connectedness score	0.008 (0.063) *1.000*	0.169** (0.070) *0.091*	0.161 (0.099) *0.364*
Prosocial identity score	−0.153 (0.112) *0.727*	0.197* (0.104) *0.273*	0.351** (0.160) *0.273*
Wellbeing score	−0.116 (0.131) *0.909*	0.077 (0.068) *0.727*	0.193 (0.162) *0.818*
Emotional self-regulation	0.088 (0.097)	0.087 (0.077)	−0.002 (0.110)

	0.909	*0.727*	*1.000*

Note: This table reports the estimate of the intention-to-treat impact of Your Choice on three different subsamples, defined by whether the young person was assessed by their practitioner as having a low risk rating or a medium to high risk rating (in the practitioner baseline survey). Figures in parentheses show standard errors of estimates. Asterisks (*, **, ***) signify statistical significance at 10%, 5% and 1%, respectively. In each cell, we report the point estimates, the standard error (in parentheses), and, in italics, the p-value of a test of the null hypothesis that the coefficient is zero, adjusting for multiple hypothesis testing across all secondary outcomes.

CYPs = children and young people

Additional analyses and robustness checks

This section examines the robustness of the estimates of the key parameters of interest, the adjusted mean difference in primary and secondary outcomes between the treated and control groups, which measures the ITT of Your Choice on these outcomes.

Table 18 reports the results of two types of robustness checks specified in the protocol but enriches the analysis with four additional models:

- Unadjusted mean differences (column 2)
- Mean differences only adjusted for LA means in outcomes (column 3)
- Mean differences only adjusted for LA means and baseline outcome (column 4)
- Mean differences for binary outcomes estimated via a logit model rather than an OLS model (column 5; we report marginal effects of the treatment in the table below)

For ease of comparison, Table 18 also reports in column 1 the adjusted mean differences estimated via our preferred specification (and reported in Tables 11 and 12).

The comparison of estimates across columns 1–4 is informative about the importance of controlling for particular variables in the ITT specification. As mentioned earlier, this is important because even though we can't reject that young people in the control and treated groups differ in most of the characteristics we observe at baseline at conventional levels of significance, the balance analysis does suggest that young people in the treated group may be systematically allocated the treated group on the basis of having levels of emotional and behavioural difficulties and being generally more at risk of harm. As a result, the empirical design is only valid insofar as our control set appropriately captures pre-existing differences between the two groups that are systematically related to the outcomes we study.

As Table 18 shows, the model with no controls shows mean differences that are of the same sign as those found at baseline for most primary and secondary outcomes. That is, positive mean differences in externalising behaviours (conduct problems and hyperactivity), the SDQ score for peer problems and the measures of perceived risk to the young person's safety, as well as negative mean differences in the SDQ scores for emotional problems, prosocial behaviour, social connectedness and prosocial identity.

These results are unsurprising: the model with no controls captures the raw difference in outcomes between treated and control young people across all LAs of London and is therefore likely to reflect the pre-existing differences at baseline between the two groups, which we have documented in Table 9 and Table 10.

As we add controls to the table, however, for most outcomes, these differences become smaller (in absolute value) and often change sign. Specifically, in column 3, we control for LA fixed effects, which means that we now compare the outcomes of treated and control young people within LAs (as intended by the design). In

column 4, we further control for the baseline outcome to further capture any pre-existing differences between treated and control young people within LAs that are correlated with conduct problems.

The effects estimated in this specification are highly similar to those reported in the preferred specification (which also controls for special educational needs, baseline prosocial behaviour, baseline practitioner's risk rating and perceived risk to the young person's safety), which provides us reassurance that controlling for baseline outcome is likely to already capture most unobserved differences between the control and treated groups that could confound the impact of Your Choice on outcomes.

Finally, in the last column of the table, we report the results of the logit specification for binary outcomes. These estimates do not change our main findings: they are all small in absolute terms and lack statistical significance at conventional levels.

Table 18. Robustness checks on primary and secondary analysis

Outcome	Preferred specification (LA fixed effects, baseline outcome, controls)	Model with no controls	Model with LA fixed effects	Model with LA fixed effects and baseline outcome	Logit model (for binary outcomes)
Primary outcome					
Conduct problems, high/very high range	−0.008 (0.028)	0.067* (0.036)	0.021 (0.031)	0.009 (0.025)	0.017 (0.024)
Secondary outcomes					
Hyperactivity, high/very high range	−0.039 (0.031)	0.066 (0.056)	−0.022 (0.045)	−0.031 (0.031)	0.013 (0.029)
Hyperactivity score	−0.072 (0.184)	0.620* (0.320)	0.139 (0.279)	−0.006 (0.184)	
Emotional problems, high/very high range	−0.011 (0.024)	−0.019 (0.022)	−0.037 (0.028)	−0.008 (0.023)	0.007 (0.022)
Emotional problems score	−0.157 (0.186)	−0.143 (0.165)	−0.307 (0.252)	−0.150 (0.178)	
Peer problems, high/very high range	−0.073* (0.039)	−0.008 (0.033)	−0.040 (0.038)	−0.064* (0.036)	−0.053 (0.037)
Peer problems score	−0.146 (0.168)	0.131 (0.155)	0.035 (0.197)	−0.115 (0.160)	
Prosocial behaviours, low/very low range	−0.001 (0.039)	0.058 (0.035)	0.033 (0.039)	0.016 (0.038)	0.011 (0.033)
Prosocial behaviours score	−0.034 (0.167)	−0.412** (0.182)	−0.275 (0.174)	−0.091 (0.163)	
Perceived risk to safety (self-report)	−0.094 (0.068)	0.071 (0.095)	v0.032 (0.069)	−0.058 (0.068)	
Perceived risk to safety (practitioner report)	0.092 (0.143)	0.433** (0.181)	0.300 (0.189)	0.116 (0.163)	
Social connectedness score	0.115** (0.044)	−0.020 (0.035)	0.055 (0.046)	0.085** (0.041)	
Prosocial identity score	0.040 (0.068)	−0.082 (0.058)	−0.020 (0.064)	−0.013 (0.058)	
Wellbeing score	0.045 (0.060)	−0.052 (0.041)	−0.003 (0.061)	−0.003 (0.061)	

Emotional self-regulation	0.079 (0.061)	0.087** (0.035)	0.088 (0.061)	0.088 (0.061)	

Notes: For the primary outcome and secondary outcomes, the table reports the estimate of the intention-to-treat impact of Your Choice across different specifications. In Column 2, we report the results of the benchmark specification, which controls for the baseline outcome, local authority (LA) fixed effects and baseline young person characteristics that are imbalanced at baseline. In Column 3, we report the results of a specification with no controls. In Column 4, we report the results of a specification where we only control for LA fixed effects. In Column 5, we report the results of a specification where we control for LA fixed effects and baseline outcome. In Column 6, for binary outcomes only, we report the marginal effect of the treatment estimated in a logit model (instead of a linear probability model). Figures in parentheses show standard errors of estimates. Asterisks (*, **, ***) signify statistical significance at 10%, 5% and 1%, respectively.

Missingness

To better understand the sources of attrition and implications for the analysis, we next examine patterns of missingness in the variables that we use in the analysis sample. In the second column of Table 19, we report the proportion of young people in the randomised sample (N = 1,658) who have missing data for each variable used in the equations we estimate for the primary and secondary analyses, either as dependent variables or independent variables. In the next three columns, we report the same statistic for the BAU and Your Choice samples.

Between 28 and 38% of observations in the randomised sample have missing data for at least one of the endline variables we use in the primary and secondary analyses (this is not the 44% attrition figure reported above because this figure is not only driven by missingness among endline variables but also by missingness among baseline variables included in the model). As expected, the proportion is slightly higher for the scales that were administered at the end of the endline survey (social connectedness variables, emotional self-regulation, self-efficacy) than for those administered at the beginning (SDQ and Checkpoint).

Missing data is a lot lower for variables measured at baseline – in most cases between 11 and 15%, but higher in the case of the prosocial identity score, which was not collected in the pilot trial.

We next interrogate whether the extent of missingness varies between the control and treated groups. First, we report in the fifth column the unadjusted difference in the probability of missingness of each variable between the treated and control groups. Next, we report the same difference controlling for LA fixed effects (as randomisation and identification of the effect of Your Choice is always done within LAs). That is, in the sample of randomised young people, we estimate an OLS regression of an indicator for whether the variable is missing on an indicator for treatment and LA fixed effects – we report the coefficient on treatment. In the last column, we report the p-value for the coefficient on treatment.

The unadjusted mean differences confirm a pattern already observed, which is that endline outcomes are more likely to be missing in the treatment group than in the control group, primarily because young persons in the treatment group are less likely to fill out their endline questionnaire than controls. This is not the case at baseline, where missingness is relatively balanced between treated and control across LAs.

However, when looking at differences *within* LAs, differences in missingness become much more muted for endline outcomes, and none of these differences are statistically significant. This suggests that differences in missingness between the treated and control groups in the overall sample have more to do with differences in missingness between LAs and an imbalance in the number of treated and control young people randomised within each LA, rather than systematic differences in missingness between treated and control young people within each LA. Overall, this suggests that it is very unlikely that these imbalances in

missingness would affect our main results, and we don't perform any further sensitivity analyses around missingness.

Table 19. Extent of missingness for each variable used in primary and secondary analysis, by treatment

	Proportion of randomised sample with missing data				Regression of an indicator for missingness on treatment indicator and LA fixed effects	
	Full sample	BAU sample	Your Choice sample	Difference between Your Choice and BAU	Coefficient on treatment indicator	p-value
Baseline						
Conduct problems, high/very high range	15%	13%	16%	3%	−0.004	0.909
Hyperactivity, high/very high range	15%	13%	16%	3%	−0.005	0.887
Hyperactivity score	15%	13%	16%	3%	−0.005	0.887
Emotional problems, high/very high range	15%	13%	16%	3%	−0.007	0.829
Emotional problems score	15%	13%	16%	3%	−0.007	0.829
Peer problems, high/very high range	15%	13%	17%	4%	0.007	0.828
Peer problems score	15%	13%	17%	4%	0.007	0.828
Prosocial behaviours, low/very low range	15%	14%	17%	3%	−0.006	0.866
Prosocial behaviours score	15%	14%	17%	3%	−0.006	0.866
Total risk score (self-report)	14%	13%	15%	2%	−0.007	0.852
Total risk score (practitioner report)	11%	12%	11%	-1%	−0.065	0.125
Social connectedness score	14%	12%	15%	2%	−0.011	0.777
Prosocial identity	24%	23%	25%	2%	−0.038	0.431
Special educational needs and disabilities	11%	8%	13%	5%	0.042	0.015
Practitioner's risk rating	11%	12%	11%	−1%	−0.060	0.165
Endline						
Conduct problems, high/very high range	33%	29%	36%	8%	−0.018	0.760
Hyperactivity, high/very high range	33%	29%	37%	8%	−0.014	0.822
Hyperactivity score	33%	29%	37%	8%	−0.014	0.822
Emotional problems, high/very high range	33%	29%	37%	8%	−0.012	0.836
Emotional problems score	33%	29%	37%	8%	−0.012	0.836
Peer problems, high/very high range	33%	29%	36%	7%	−0.021	0.717
Peer problems score	33%	29%	36%	7%	−0.021	0.717
Prosocial behaviours, low/very low range	33%	28%	36%	8%	−0.012	0.837
Prosocial behaviours score	33%	28%	36%	8%	−0.012	0.837
Total risk score (self-report)	34%	30%	37%	7%	−0.012	0.833
Total risk score (practitioner report)	28%	29%	27%	−2%	−0.086	0.117
Social connectedness score	33%	28%	36%	9%	−0.003	0.958
Prosocial identity score	38%	32%	43%	10%	0.008	0.900
Wellbeing score	33%	28%	37%	9%	−0.001	0.984
Emotional self-regulation score	30%	25%	33%	8%	−0.002	0.970

LA = local authority, BAU = business-as-usual

Analysis in the presence of non-compliance

As described in the methodological section above, non-compliance in the Your Choice trial is defined at a number of levels, each with distinct implications for the interpretation of the ITT results above and the subsequent analysis required in the presence of non-compliance. We discuss these issues in turn.

Non-compliance issue 1 (randomisation protocol): the composition of the young people across the control and treated teams is not balanced on average due to non-adherence to the randomisation protocol and/or selective attrition

The analysis so far presented suggests that this form of non-compliance may be at play. The balance analysis reported in Table 9 shows that, on average, the young people in the treated and control groups are systematically different along a number of dimensions. It also shows differences in SDQ scores at baseline, pointing in the direction of more severe difficulties in the treated group, though, for most dimensions, these effects are not statistically significant at conventional levels.

Furthermore, the analysis of attrition and missingness (Tables 8 and 19) reveals some differences in the likelihood of completing surveys across the treated and control groups, but the extent to which missingness for variables used in the primary and secondary analyses is systematically related to treatment is small and rarely statistically significant.

The adjusted mean difference reported in Tables 11 and 12 can be interpreted as the causal effect of being allocated to Your Choice if and only if the treated and control groups did not differ in unobservable ways that affect outcomes once the covariates included in the model (baseline outcome and imbalanced characteristics at baseline) were controlled for.

For the primary outcome and most secondary outcomes, we include the baseline outcome in the model. The fact that the baseline outcome is highly predictive of the endline outcome provides some reassurance that, conditional on baseline controls, LA fixed effects and unbalanced covariates, our estimates are consistent with the identification assumption that the treatment and control groups are comparable. Implicitly, we assume that the pre-treatment outcomes capture any remaining unobserved differences between the treated and control groups that matter for the outcome of interest.

Non-compliance issue 2 (low dosage in the treated group): the Your Choice programme is not implemented with fidelity or only with partial fidelity

Implementing the Your Choice programme with fidelity requires that

- All practitioners in teams randomised to deliver Your Choice receive the full amount of training required by the programme designers.
- Young people in the Your Choice teams meet with their practitioners three times a week for 12 weeks (over the course of 12–18 weeks).
- Sessions delivered in the Your Choice group include CBT-informed elements of the Your Choice training programme.
- Trained practitioners meet with their clinical supervisors at least monthly to discuss progress and the cases assigned to them.

The analysis reported in the IPE section below provides evidence that the majority of these conditions were not adhered to during the efficacy phase of Your Choice (analysis of fidelity during the pilot trial was reported

in the pilot trial report and suggested some issues with implementation, although the data collected did not allow as full of a treatment of the issue of fidelity as is possible in this report).

As reported in the IPE section below, the proportion of young people in the Your Choice group who received the 36 sessions was too small to estimate the impact of receiving this full treatment (versus a lower dosage). Instead, we focused on estimating a dosage effect, which we measured in two ways: whether the young person received any Your Choice sessions and the number of Your Choice sessions received. These measures of dosage are endogenous, so we use an IV approach, in which we instrument them using the treatment allocation. The first stage regresses the dosage variable on the same explanatory variables used for the ITT analyses and the instrument (with standard errors similarly clustered at the LA fixed effects). The second stage regresses the outcome variable on the predicted dosage from the first stage, along with the explanatory variables included in the first stage.

Table 20a and Table 20b report the results of this analysis for the two measures of dosage (any Your Choice session and the number of Your Choice sessions, respectively) for the primary outcome. Note that this analysis uses only observations from the efficacy trial, not the internal pilot, because the collection of session forms during the pilot was insufficient to enable this analysis. The second and third columns of these tables report the estimates of the coefficient on the treatment indicator in the first stage. As expected, it is positive and highly statistically significant (p-value < 0.001), as being allocated to a Your Choice team is strongly positively correlated with the number of Your Choice sessions received.

The fourth and fifth columns report the coefficient of the number of Your Choice sessions in the second stage and the associated p-value. In both cases, the coefficient is positive. At face value, they point to a non-negligible positive impact of treatment on the primary outcome, implying that higher dosage is associated with an increase in the probability of a worse outcome among compliers. However, these estimates lack statistical significance at the usually accepted levels and, hence, need to be interpreted with caution.

Non-compliance issue 3 (contamination of the control group): young people in the control group receive the Your Choice programme or some elements of it

A full analysis of contamination is reported in the IPE section below, and it suggests that a small fraction of young people in the control group did indeed receive Your Choice sessions. This could be due to practitioners in the control teams receiving Your Choice training or learning about the programme from their trained peers in the LA.

The IV analysis that we just presented, which leveraged data on the number of Your Choice sessions practitioners reported delivering (both in control and treated teams), addresses the contamination issue by focusing on the effect of actually receiving Your Choice sessions. Unfortunately, however, the analysis is too imprecise to draw firm conclusions.

Table 20a. Effect of receiving any Your Choice sessions on conduct problems

Outcome	IV first stage		IV second stage	
	Coefficient of treatment (standard error)	p-value	Coefficient of an indicator for any Your Choice sessions (standard error)	p-value
Primary outcome				
Conduct problems, high/very high range	0.559 (0.062)	<0.000	0.071 (0.047)	0.127

IV = instrumental variable

Table 20b. Effect of the number of Your Choice sessions on conduct problems

Outcome	IV first stage		IV second stage	
	Coefficient on treatment (standard error)	p-value	Coefficient on number of YC sessions (standard error)	p-value
Primary outcome				
Conduct problems, high/v high range	8.373 (1.733)	<0.000	0.006 (0.004)	0.142

IV = instrumental variable

ICC and power

We estimate the ICC (at the team level) to be equal to 0.073 for the primary outcome. This is lower than what we assumed in the power calculations – a value of 0.12 in the first version of the protocol and a revised value of 0.09 in the second version.

The other key assumption in the power calculations was around the mean of the primary outcome in the control group. In the endline sample, the likelihood of young people in the control group reporting high to very high levels of conduct problems was 18%, which is much lower than what was assumed in either the first version of the protocol (30%) or the second version (60%).

While the lower-than-assumed ICC would have increased the actual power of the trial relative to the power calculations, the lower-than-assumed mean of the primary outcome in the control group would have reduced the actual power of the trial.

IPE results

The IPE addressed five RQs:

IPE -RQ1. To what extent is Your Choice delivered as intended?
IPE -RQ2. To what extent is the delivery of Your Choice different from and similar to BAU?
IPE -RQ3. What are the barriers to and facilitators of delivery?
IPE -RQ4. What are young people's and practitioners' views and experiences of Your Choice (acceptability, impacts and mechanisms)?
IPE -RQ5. What are practitioners' views on the sustainability of Your Choice?

IPE-RQ1 and 2. To what extent is Your Choice delivered as intended? To what extent is the delivery of Your Choice different from and similar to BAU?

Training of practitioners

Data on the training of practitioners was collected directly from LAs: it was intended that LAs would provide the names of all practitioners who underwent some or all of the Your Choice training, along with the first and last days of training for each practitioner.

The data received via the LA workbook did not allow for such detailed analysis. Nine LAs did not provide any information about training, even though we know from the implementation team that some training was offered to practitioners in their Your Choice team(s). Moreover, the data on training dates was incomplete, and very often, only a start or a finish date was provided in the LA workbook.

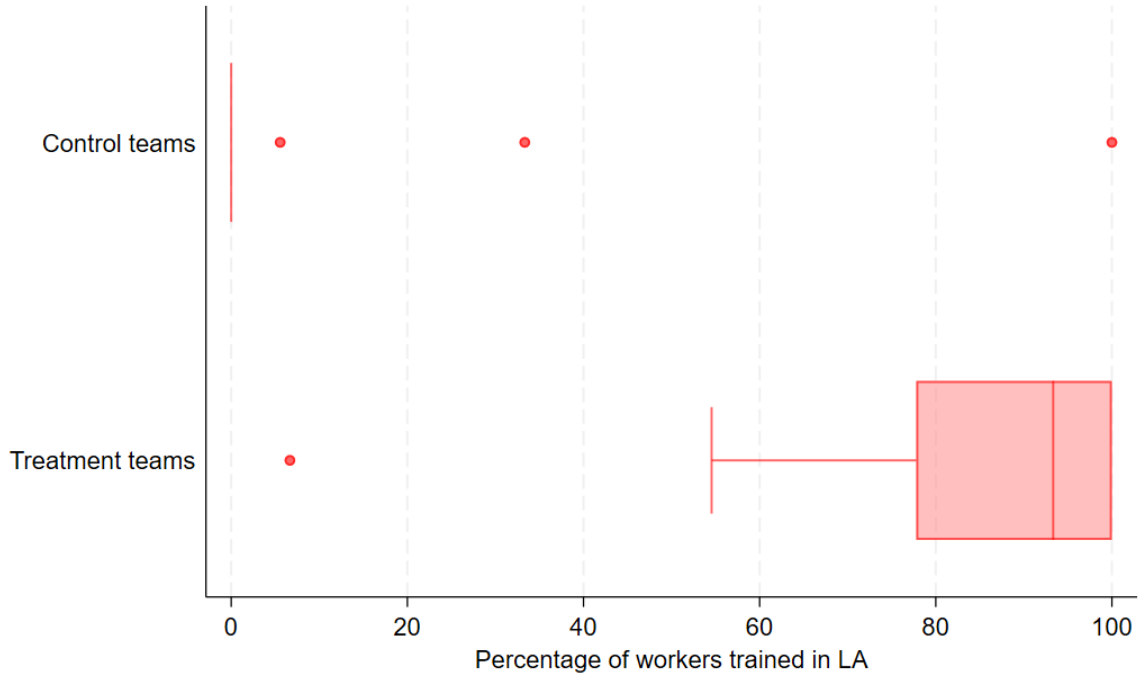
Acknowledging these data limitations, we still provide some descriptive statistics on the proportion of practitioners in each LA who completed some Your Choice training, broken down by control and treatment groups. We marked a practitioner as having completed some Your Choice training if a start date and/or a finish date was provided on the LA workbook.

The boxplots in Figure 4 show the distributions of this variable by treatment condition. The median in the control group is 0, but three LAs reported a strictly positive number of practitioners in BAU teams who underwent some training, so the mean percentage of practitioners in control teams is 4%.

In the treatment group, the median percentage of practitioners who underwent the training was very high, at 93% (the mean was 83%). Moreover, nine LAs out of 24 with non-missing data had 100% training rates, and only two LAs had training rates below 50%.

Overall, notwithstanding the limitations of the available data, we conclude that there was fairly strict adherence to the training protocols, with a large fraction of practitioners in the Your Choice teams undergoing training and the majority of practitioners in the BAU teams not undergoing training. However, this adherence was not perfect: in a few LAs, there does seem to have been some contamination of the BAU teams, with some practitioners undergoing the Your Choice training, and some lack of adherence to the intended implementation of this aspect of Your Choice, with some practitioners in the Your Choice teams not undergoing the training.

Figure 4. Distribution of the percentage of practitioners involved in the trial recorded as having completed some or all of the Your Choice training, by treatment condition of their teams



LA = local authority

In the qualitative data, trainers felt that the training had provided practitioners with **a variety of tools** to draw upon in their work with young people.

> *"What we do is we have a range of tools, we share everything, and then we allow the practitioner to use the one he or she feels is more suitable because they're the ones [who] know better their cases and their young person".*

In line with the principles of the programme, they described **making adaptations to the training** to include relevant professional experiences, with the aim of making the training more relatable for practitioners. They mentioned adding extra resources to clarify more difficult concepts, adding extra activities and being flexible with scheduling the training. Additionally, trainers highlighted the need to adapt the training to suit the needs of young people in their area, and to consider EDI in their individual communities: *"The examples that we do use, we had to make some adjustments because we needed that localised and to make more sense to what we do"*.

Trainers spoke about using or adapting the slides provided by the Your Choice team to facilitate the training, for instance, by adding case study examples: *"One of the things we did was we included a case study. So we created a family that we then used throughout the rest of the training to refer to and use in exercises"*. Trainers also mentioned linking the training content to real cases and focusing on the specific population that the practitioners would be working with: *"We would ask them to bring their own cases for us to explore, … process and make formulations from. And throughout, we would encourage them to think of a young person, as well as thinking of their own experience"*.

Trainers reported that the Your Choice training was often delivered by two or more trainers together. Training was generally two to four days long, spread out across two or more weeks. Training was almost entirely conducted face-to-face, though one trainer mentioned delivering a hybrid training session: face-to-face and online. Trainers felt that the characteristics of the physical training space were important.

"We didn't have the training centre available for us. There were no rooms, so we had to do it in another part of the building ... I think it affected the training because it was more like being trained in an office, and that could be very limiting, rather than when you are trained in a training centre that is more friendly with the space".

Trainers mentioned offering **booster or refresher training sessions** to practitioners: *"We came back together a couple of months later and did refresher trainings, and that would look like, 'Where are they now and how have they found it?"* The sessions were generally one day long, taking place one to two months after the initial training sessions. Topics covered in booster training sessions included celebrating practitioners' achievements and checking in with practitioners about how they were getting on in terms of delivery.

Practitioners described **learning about CBT** during their Your Choice training, including the theory underpinning it and activities linked to this, with examples of what these could look like in practice: *"We looked at what CBT was and how we can use it and what that practically looked like in different stages"*. They described the training as **interactive in its approach**, with valuable opportunities to hear from others who had experience delivering Your Choice.

However, **not all practitioners had received the training or the Your Choice resources** (e.g. the workbook) before they started delivering Your Choice. Practitioners mentioned that their training ending prematurely, such as because their trainer had left or because the practitioner themselves had to respond to an emergency: *"I remember feeling, like, a bit frustrated that I had to pull myself away because I didn't get, like, the full training"*. They mentioned colleagues not receiving the training at all because they were unable to attend at the scheduled time. They described struggling to engage with the training when it was not interactive enough or when it was delivered online.

Practitioners also mentioned that they had received the training a long time ago, and they had not had a refresher session since then: *"I'd probably need a refresher on it all because it was so long ago. I don't feel that confident in some of the techniques"*. Trainers also indicated that **refresher or booster training was not always offered**. Moreover, when booster training was offered, trainers felt that it was not always delivered at the most effective time: *"The vast majority of people, they still hadn't been handed a Your Choice case. And so, the four-week follow-up really was just not very … it just didn't do anything"*.

SPoCs, leads and managers spoke about the **issues that they had experienced in terms of cascading the Your Choice training** within their services. This included training too many practitioners in Your Choice, which had risked contamination of the control teams, finding that the training was resource-intensive to run and feeling that the training was too long.

"I don't mind running it, but it's just trying to find the time between myself and two clinical leads and fitting into the practitioners' schedule. They have to … [agree] to be freed up by their manager; there has to be cover".

Number of sessions

Based on data collected via session forms, we provide descriptive evidence on the number and content of sessions performed in the context of supporting young people in the Your Choice and BAU teams. We focus on direct sessions, which we define as sessions delivered to young people, their parents/carers and/or their sibling(s). If a session involved a young person, they had to have attended the session for us to include it. Attendance records for parents/carers and siblings were not recorded; however, the majority of sessions

involved young people, as discussed below. The analysis is restricted to young people included in the primary analysis sample and those who joined the trial during efficacy, as session form data was too sparsely collected during the pilot.

Table 21. Descriptive statistics about the number of direct sessions, by treatment condition

	Young people in the treated group (n = 457)	Young people in the control group (n = 419)
No. of sessions	3,888	1,415
Range	0–40	0–30
Mode	0	0
Mean (SD)	8.131 (7.922)	3.377 (5.483)
Mean difference (SE)	5.131*** (0.464) p-val < 0.000	
Cohen's D ES (SE) p-val	0.701*** (0.063) p-val < 0.000	

SD = standard deviation, SE = Standard Error

As shown in Table 21, overall, 3,886 and 1,413 sessions were delivered to young people included in the primary analysis from the treated and control groups, respectively. Young people in the Your Choice group received significantly more direct sessions than young people in the control group: an average of eight sessions per young person was delivered in the treated group compared to an average of three sessions per young person in the control group, and the difference in the number of sessions per young person is statistically significant.

Within each treatment group, there is great variability in the number of sessions received. The standard deviation of this variable in the treated group is 7.93, while it is 5.47 in the control group. Figure 5 shows this variability further through a histogram of the number of sessions received by each young person during the study, by treatment condition. Almost 40% of young people in the control group received no sessions, and almost all of the rest of the group (48%) received between one and nine sessions.

The three most frequent numbers of direct sessions in the Your Choice group were one to nine sessions (47%), no sessions (16%) and 10–19 sessions (26%). Less than 1% of young people receive 36 or more sessions during their time in the study. Given that Your Choice practitioners are supposed to have 36 contacts with young people, their parents/carers or relatives during Your Choice, this means that full compliance with the intended number of sessions was extremely rare.

In the qualitative data, SPoCs, leads and managers described their services as responsive and reactive, which meant that any new programme had to be relatively flexible in this context in terms of its delivery: *"You have to go in, I think, with that sort of mindset, you know, you can't think of this programme in a very … linear way because things change"*. In particular, they referenced the importance of **being responsive to young people's needs**, such as in terms of how much contact they wanted with their Your Choice practitioners each week: *"If they don't want to meet three times a week, then we won't push it because we run the risk of them dropping out"*.

SPoCs, leads and managers reported **issues raised by practitioners in relation to the three sessions per week element of Your Choice** and the administrative tasks required. Flexibility around this, such as in terms of what sessions could entail (e.g. a phone call rather than an in-person session), was key to making this more palatable from SpoCs', leads' and managers' perspectives.

> *"If the young person's only happy to engage once a week or if you can keep in contact with them through texts and email or WhatsApp, then, you know, that actually is good enough. Because it is about building the relationship".*

Likewise, practitioners discussed the difficulties that they had faced in terms of fitting in up to three sessions with each young person per week during the Your Choice programme: *"I understand it's like positive outcomes, but three times a week engagement when we've got a full-time caseload is near on impossible"*. Factors behind this included the practitioners themselves not having the capacity to do this and young people not wanting to or being able to engage in so much contact with practitioners: *"I think Your Choice has got the right idea. I think it's just the clash with the reality of our own workloads and availability of the young people"*.

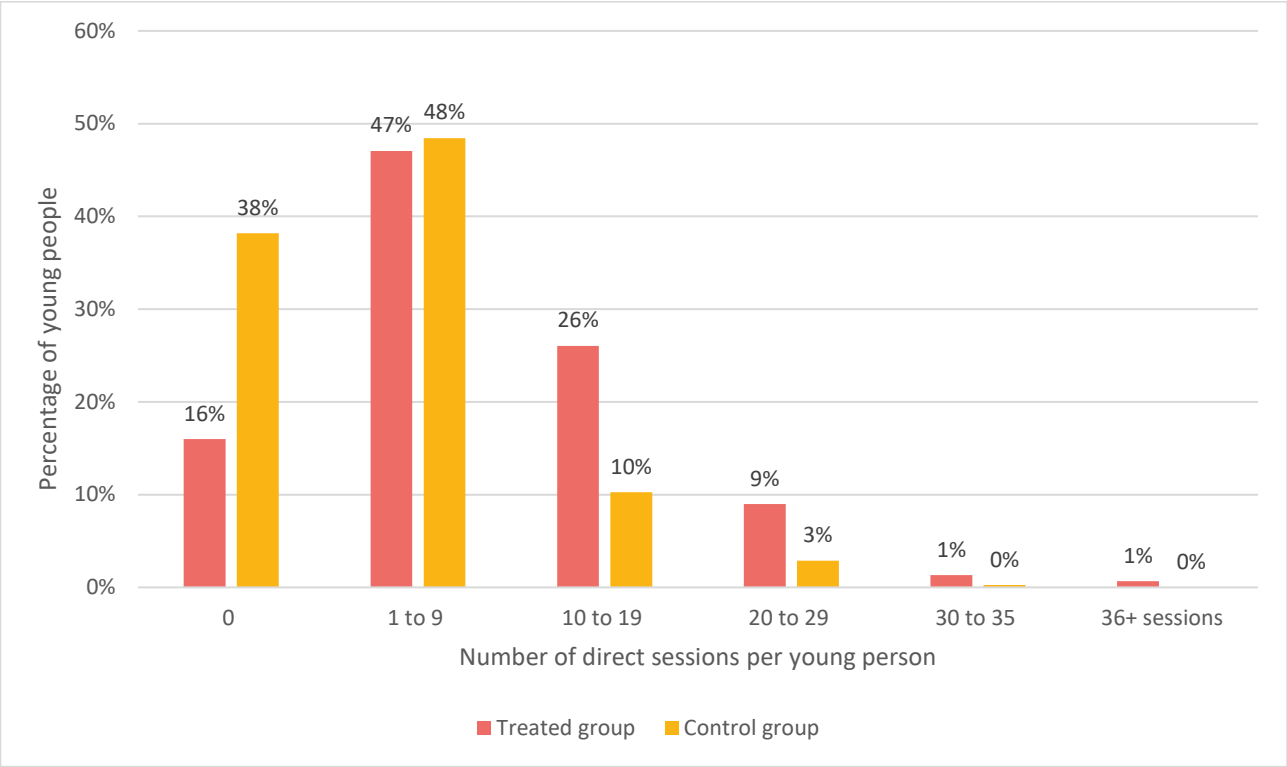
Practitioners described ways that they had managed this: *"I think as we've gone through and got to know the programme better, [there are] ways I think we can do it where the capacity isn't as much of an issue"*. These included having phone or text contact with the young person or their family instead of a face-to-face session with the young person, having group sessions with their Your Choice cases or prioritising their perceptions of young people's preferences and needs when deciding how much contact to have each week: *"I've just tried to do it like as much as possible or as much as the young person needs. And I don't think my young people need or want to talk to me three times a week"*.

However, practitioners also noted the **advantages of the regular and frequent contact that they had with young people** through Your Choice: *"I think just having like a yeah, a regular sort of space for a young person to sort of meet and talk with you, um, I think for them has been really valuable"*. Principally, they felt that seeing Your Choice cases more than they usually would see other cases had helped them to build relationships quickly and to strengthen their relationships with young people.

Trainers similarly mentioned that the time commitment that Your Choice required for practitioners to work with young people allowed for stronger relationships to develop. They felt that this contributed to young people's engagement with Your Choice. However, trainers also felt that practitioners were not always engaging with young people regularly enough or felt that the programme length was still too short for practitioners to develop meaningful relationships with young people:

> *"I was very adamant with my practitioners that the relationship is the most important thing, the trust. Before they do anything, the trust is the most important thing. And, in some instances, that had to build before they could get them to consent to a hook. So, if I look back, is 12 weeks long enough? No, I don't think it's long enough".*

Figure 5. Binned distribution of direct sessions per young person, by treatment condition



Note: This graph shows the proportions of young people who have different numbers of direct session forms. This analysis is conducted on young people who were part of the analysis sample and who joined the trial in the efficacy phase (N = 876).

Features of sessions

Further descriptives on the direct sessions are shown in Table 22. Most direct sessions in both groups were delivered to young people, with a small number delivered to parents, carers and siblings.

Table 22. Descriptive statistics about the user, duration, location and young person's engagement in direct sessions

	Treated group		Control group	
Number of sessions by service user[1]	**No. of sessions**	**%**	**No. of sessions**	**%**
Young person	3637	93%	1385	98%
Parent/carer	601	16%	87	6%
Sibling(s)	141	4%	34	2%
Location of session	**No. of sessions**	**%**	**No. of sessions**	**%**
School	890	23%	445	31%
Community	541	14%	176	12%
Local authority building	852	22%	570	40%
Outdoors	171	4%	10	1%
Someone's home	775	20%	117	8%
Other	651	17%	96	7%
Missing	8	0%	1	0%
Young person's engagement in sessions				
No. of sessions with engagement scores	3793		1379	
Mean (SD)	4.526 (0.933)		4.503 (0.986)	

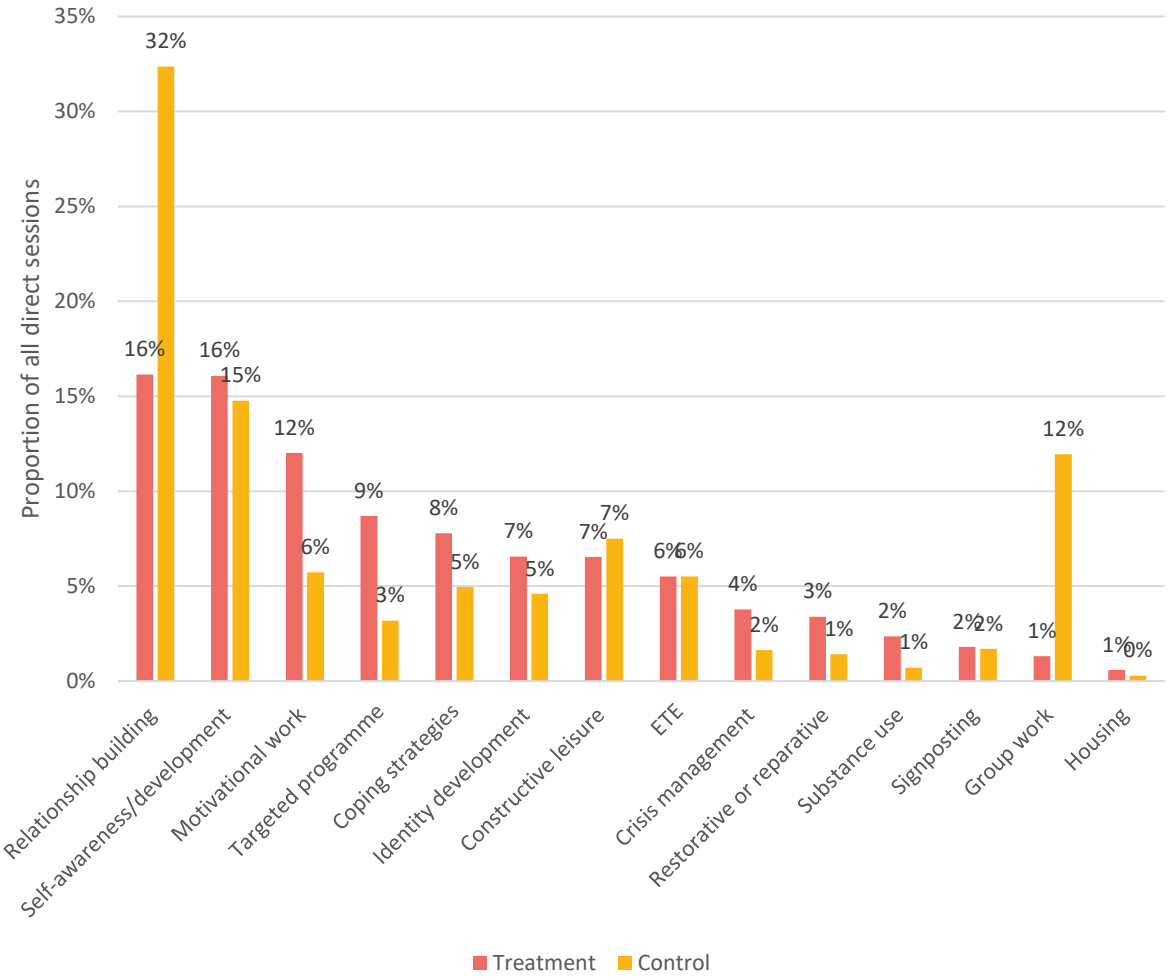
Note: [1] The numbers of sessions by service user, direct work type and Your Choice session content are not mutually exclusive. Direct sessions are those delivered to a young person, parent/carer or sibling. For direct sessions delivered to a young person, the young person had to have attended the session for it to be included. This analysis was conducted on the sample of young people who had at least one direct session form collected during the efficacy part of the trial.
SD = standard deviation

Regarding the location of sessions, a greater proportion of sessions (descriptively) in the control group were delivered in an LA building (40%) or school (31%) than in the Your Choice group (22% in an LA building and 23% in a school). In contrast, a greater proportion of sessions (descriptively) were delivered in someone's home in the treated group (20%) than in the control group (8%). Young people's level of engagement in sessions, rated by the practitioner, was similarly high across both groups. In both groups, the mode is 5 (out of 5). The mean engagement in Your Choice is almost identical to that in the control group (4.52 vs 4.50).

Session content

In the session forms, practitioners rated the type of session conducted with the young person. As shown in Figure 6, the three most frequent general types of session for the Your Choice group were relationship building (16%), self-awareness or development (16%), and motivational work (12%). The three most frequent general types of sessions for the control group were relationship building (33%), self-awareness or development (15%), and group work (12%).

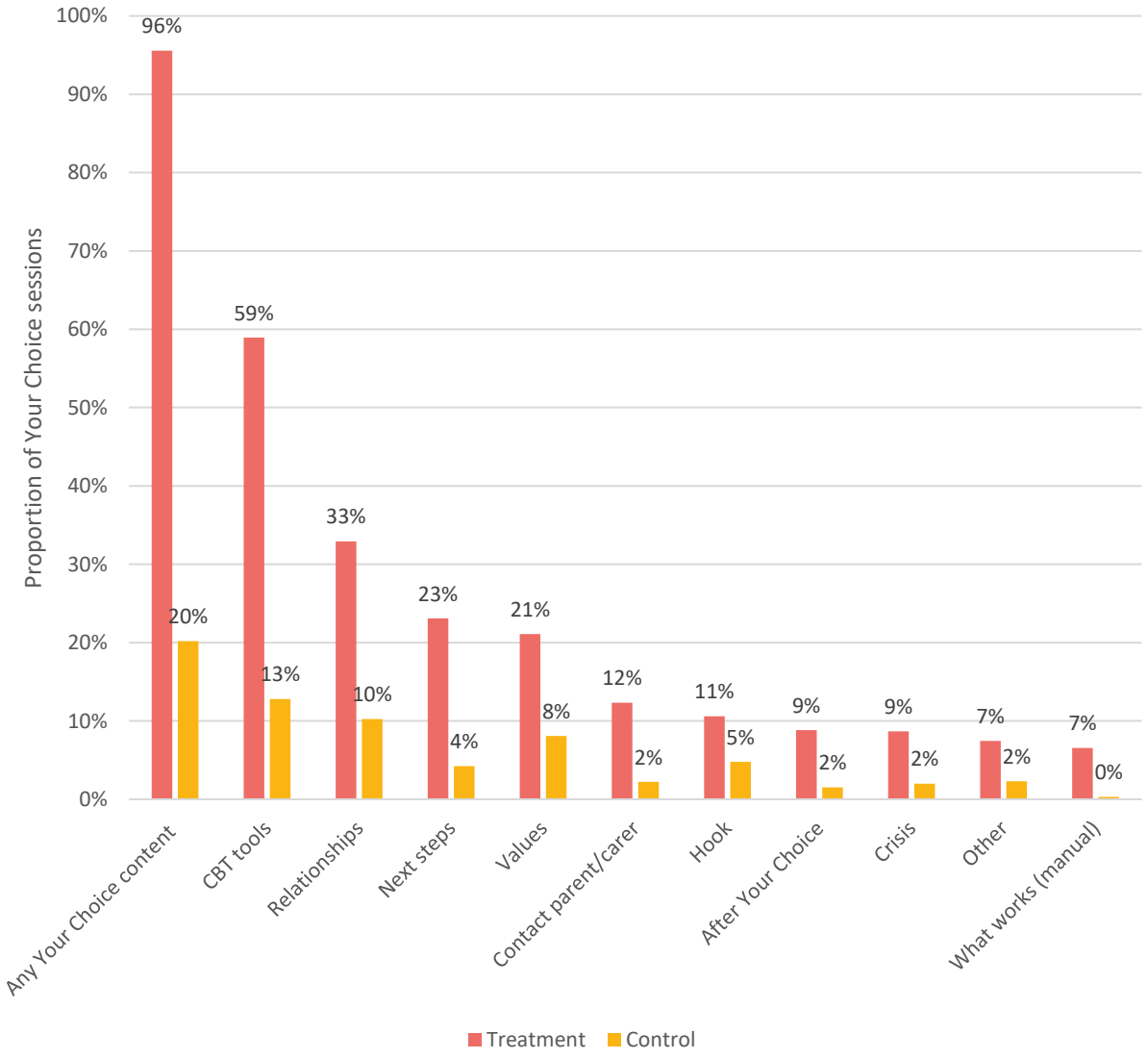
Figure 6. Proportion of all direct sessions including a certain type of content



Practitioners were also asked whether the session used Your Choice tools and techniques and, in this case, what type of Your Choice content they administered. As indicated by the first two bars in Figure 7, in the Your Choice group, the majority (96%) of young people with at least one direct session, or 80% of the overall sample, had at least one session recorded as a Your Choice session. Surprisingly, 20% of the control group with at least one direct session, or 12% of the overall sample, had at least one session recorded as a Your Choice session.

Figure 7 shows the percentage of Your Choice sessions with different types of content (where practitioners could tick all that applied). For the Your Choice group, a large proportion of Your Choice session types (58%) used CBT tools, in line with the theory of change. Other frequent types of Your Choice sessions for the Your Choice group were relationships (33%), next steps (23%) and values (21%).

Figure 7. Percentage of direct sessions with any or any particular Your Choice content



Overall, we conclude from the session form data that adherence to the protocol was quite strict in terms of session content but not in terms of the frequency of sessions. There also appears to have been a non-negligible amount of contamination of the control group by being exposed to Your Choice sessions.

In the qualitative data, practitioners described tailoring the Your Choice programme to meet young people's needs and contexts, **taking a flexible approach to delivery**. They mentioned adjustments that they had made primarily with **consideration of young people's learning difficulties, speech and language needs, and**

neurodivergence. This included using more visual exercises or conversation-based activities, rather than completing worksheets or written activities with young people, and using simpler language.

> *"I've actually spoken to a speech and language therapist in our team, and she's going to sit down, I think, with us as a team and try and adapt, like, many of the worksheets to make them easier for young people because such a significant proportion of our population, client population, have speech and language needs".*

Practitioners mentioned **issues that they had identified with the programme content and resources** that they had needed to address during delivery. These included repetitiveness of content, the need for the workbook and activities to be more engaging for young people and the content being too mature or abstract for younger age groups: *"It just feels very rigid and clinical. It needs to be more interactive, maybe"*. Creatively adapting the materials to the needs of the individual young person was in line with the training. They sometimes had difficulty with young people setting feasible goals and finding tangible steps to reach their goals: *"You don't want to tell someone what their goal should be, but because there's so much free rein, it makes it really challenging"*.

Trainers similarly spoke about how the Your Choice programme was **continually evolving and adapting**, with alterations being made over the course of the programme, which gave them flexibility in their delivery of the training: *"Your Choice is ongoing construction. It's building something. It's unfinished work, so we're always learning, and we always continue to develop this practice".*

Clinical supervision

In total, 1,593 (Your Choice) supervision sessions were delivered to 570 practitioners in the Your Choice group, and 135 (Your Choice) supervision sessions were delivered to 234 practitioners in the control group.

Practitioners in the Your Choice group received significantly more supervision sessions than practitioners in the control group (Your Choice M = 2.79, 95% confidence interval [CI] = 2.4, 3.19; control M = 0.58, 95% CI = 0.3, 0.85).

However, practitioners in Your Choice did not receive as much supervision as intended. Assuming a practitioner's Your Choice cases were concurrent and the case duration was 12 weeks, practitioners should have received at a minimum three monthly supervision sessions. The supervision data suggests that the number of practitioners who received three or more supervision sessions in the Your Choice arm was 159 (27.9%), and in the control arm, it was 23 (9.8%).

Moreover, as clinical supervision was intended to be part of delivering Your Choice, it appears there was some contamination with practitioners in the control group receiving supervision.

The qualitative data indicated that clinical supervision typically occurred monthly, although some practitioners reported more frequent supervision sessions. Practitioners viewed their clinical supervision sessions as **a much-needed space** to talk about their cases with a colleague (often external) with psychological expertise. Their supervisors helped them manage the emotional load of their cases and gave them advice or a different perspective. They had found both individual and group supervision sessions helpful: *"Hearing about other people's kind of cases, some brainstorming, reflective practice and all that kind of stuff, that's been helpful"*.

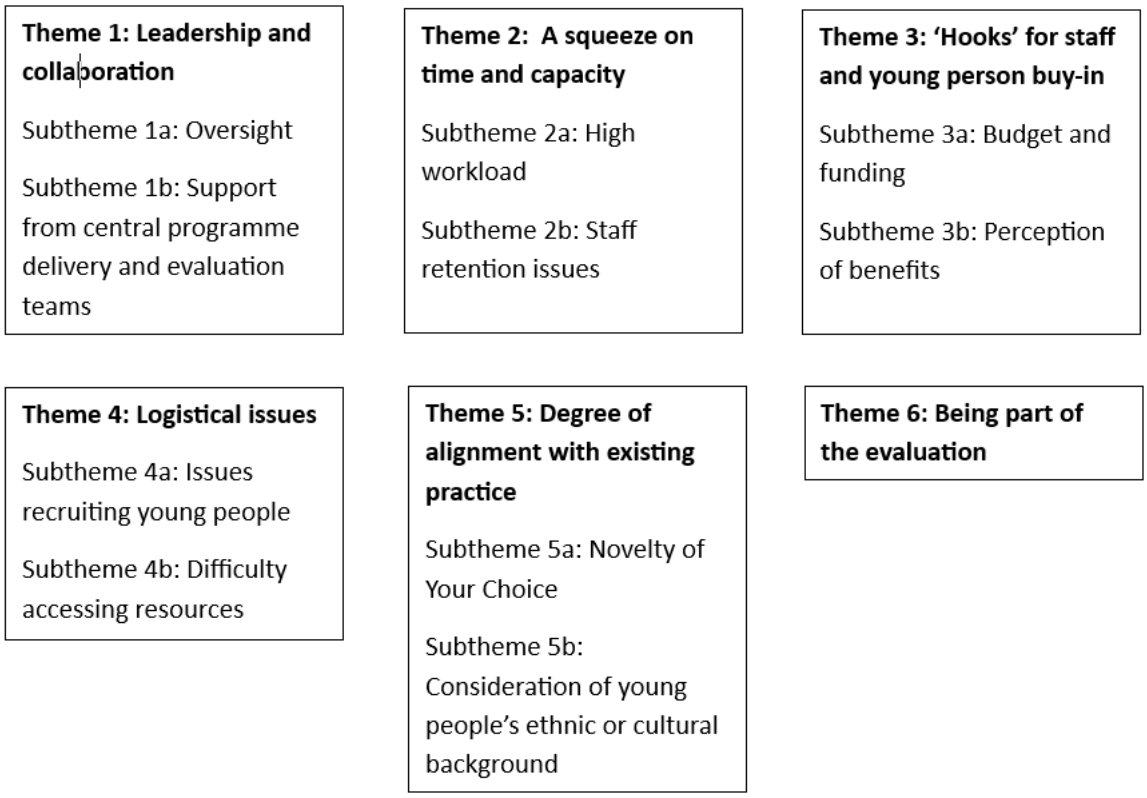
Practitioners referenced particular issues that they had discussed during their clinical supervision sessions to inform their work with young people. These included, for example, the degree to which to involve young

people's families in sessions, approaches to goal-setting with young people and understanding young people's engagement or relationship style: *"It was helpful in clinical supervision to understand that it's because of this young person's attachment difficulties that he's got me in a push–pull"*.

However, **not all practitioners received regular clinical supervision** as part of their role: *"When I have had them, they've been really good, and like I really appreciate actually having them. But I guess that's why I miss that I'm not having them"*. Turnover of supervisors and difficulties finding supervision dates that aligned with practitioners' diaries affected this: *"I did not have time in my diary to book any supervision"*. Sometimes practitioners felt that the clinical supervision unnecessarily took up their time, such as when they did not feel they needed it or when it duplicated what they already had in terms of supervision within their teams. Individual supervision could also be more productive than group supervision.

IPE-RQ3. What are the barriers to and facilitators of delivery?

Figure 8. Summary of main themes and subthemes relating to IPE-RQ3 – barriers to and facilitators of delivery.



Theme 1: Leadership and collaboration

Theme 1 describes SPoCs', leads' and managers' reflections on the importance of leadership and oversight of the LYPS within their services, as well as the collaboration required between services and central programme delivery and evaluation teams to deliver the LYPS successfully. It contains two subthemes: 1a. Leadership and oversight, and 1b. Support from central programme delivery and evaluation teams.

Subtheme 1a: Oversight

SPoCs, leads and managers indicated that their roles consisted of ensuring that all staff understood the LYPS and the expectations of them, having regular progress and problem-solving meetings with staff, motivating staff to continue recruiting young people and delivering the Your Choice programme, managing data flows

from services to the evaluation team, and reminding staff of outstanding tasks. Setting up an LYPS steering group within services was helpful, as it gave multiple senior staff members oversight of the programme: *"Collectively, that's the group that [oversees] and [facilitates] the delivery above [the] practitioner level, really. So it's a really, really good way for everybody to have good oversight on what is happening, good oversight on what needs to happen"*.

Subtheme 1b. Support from the central programme delivery and evaluation teams

SPoCs, leads and managers appreciated the support that they received from the central programme delivery and evaluation teams, including the weekly drop-in sessions they had set up and their availability to be contacted by email. They liked the opportunities they had to meet others involved in the project, such as through the weekly drop-in sessions, and to learn from other LAs' experiences.

> *"I think there's a lot of thought that's gone into the roll-out and the support. I think sometimes, like projects are like, 'Oh, go off and do this'. They chase you and [are] like, 'Why haven't you done this?' Whereas this is like an offer of support".*

However, SPoCs, leads and managers also felt that sometimes the messaging from the central programme delivery and evaluation teams was confusing, such as when guidance about the programme changed over the course of delivery. It was also not always easy to know who the best person was to contact about a query.

Theme 2: A squeeze on time and capacity

Theme 2 describes trainers', SPoCs', leads', managers' and practitioners' reflections on the pressure that practitioners and other staff are under and how that can make it difficult to implement a new programme. Theme 2 contains two subthemes: 2a. High workload, and 2b. Staff retention issues.

Subtheme 2a: High workload

Trainers referenced practitioners' existing high workloads and described how this, at times, reduced their capacity to engage in the new programme, including the training. Trainers acknowledged that it could be difficult to find time to schedule the four-day training, as well as for practitioners to meet with young people three times a week and facilitate activities:

> *"And sometimes, the nature of the activities that we do may take time. For example, [if] you want to do a go-karting activity with a young person, you can't do that in one hour. You probably need three hours with that young person. So you can't do that with a caseload of 20 cases or 25".*

Trainers described how difficult it was to engage practitioners in the programme, as they were already pushed to the limit with their current caseload. They also reflected that sometimes practitioners felt forced to implement Your Choice without a clear rationale or explanation of its benefits.

> *"Whenever you try to get practitioners to do something new or something that requires another form to be filled in, you're always going to have resistance. That's because people are doing the best that they can, they're pushed to their limit. So, straight away it never… I don't think whatever you introduce, it never goes down very well".*

SPoCs, leads and managers described how Your Choice had added to practitioners' already high workloads: *"Exhausted people, it's hard to convince [them] to do new things"*. They referenced needing to sell Your

Choice and motivate practitioners to deliver Your Choice on top of their existing workloads. They mentioned competing priorities (e.g. safeguarding issues) that would prevent practitioners from engaging with Your Choice tasks and meetings. Ofsted inspections of services could make the squeeze on practitioners' time and capacity more pronounced. Lack of time and capacity could also prevent services from providing clinical supervision for practitioners.

Similarly, practitioners described the additional workload that Your Choice had presented on top of their existing workloads, which meant that they had a lot of competing priorities to manage: *"If I knew that my job was solely to work with the young person, this would work much smoother. It would work smoother. But my job is not that. My job is [the] whole family. So that dilutes my attention"*. Practitioners' time and capacity issues were compounded when they were already overstretched in their roles, either due to a too-large caseload or staff turnover.

> *"I think having a reduction in the number of families we work with could have been helpful. Because we are being asked to do more work for that family than we were if it's just another family we were being referred [to work with] the way that we usually do".*

Subtheme 2b: Staff retention issues

Trainers described difficulties in terms of changes of service clinical leads, which led to challenges in delivering the training and led to teams feeling unsettled. High staff turnover was also highlighted by SPoCs, leads and managers as having a further negative impact on services' capacity to implement Your Choice: *"Your Choice got kind of parked because our general bread and butter wasn't even being done because we lost so many people"*. Staff turnover meant that young people's involvement in Your Choice could end if their practitioner left, services could lose entire control or treatment teams, or clinical supervision did not take place.

Theme 3: 'Hooks' for staff and young person buy-in

Theme 3 describes the hooks that, from practitioners', SpoCs', leads' and managers' perspectives, had contributed to staff and young people's buy-in to Your Choice. Theme 3 contains two subthemes: 3a. Budget and funding, and 3b. Perception of benefits.

Subtheme 3a. Budget and funding

SPoCs, leads and managers mentioned receiving reminders from senior colleagues about the links between programme funding and recruitment targets.

Having a budget readily available to do activities with young people through Your Choice was an element of the programme that SPoCs, leads and managers felt that practitioners had really bought into.

> *"Once they've got it and once they've started to deliver it and once they know, 'Actually I'm not going to sit and do … an hour's talking narrative work with my young person; I'm going to take them to the climbing wall. I'm going to take them horse riding […] I'm going to see the joy on their faces as they get involved in this stuff'".*

Practitioners similarly described how the budget that they could access quickly through the Your Choice programme to facilitate young people's involvement in activities was a key hook for engaging young people in the programme: *"I think that was the biggest selling point for me, for this young person, because he had something to look forward to"*. This included sports activities (such as a gym membership or boxing), going

out for food together, cooking, and art and music activities. Not only did young people enjoy the activities, but they gave practitioners another setting within which to conduct their sessions: *"He started boxing last week, and he's loving that, so actually, just peppering him with little questions while he's doing it"*. Practitioners had also used the budget to buy young people equipment, such as a laptop for school or revision books for exams, or to arrange driving license applications.

Subtheme 3b. Perception of benefits

SPoCs, leads and managers described highlighting the benefits of Your Choice to staff, such as the professional development opportunities it provided practitioners in terms of increasing their skillset through the development of CBT skills, to motivate them. They also described how staff seeing the benefits of Your Choice for young people was an important motivating factor: *"Seeing the children [who] have really benefitted, you know, it's kind of like good news stories, you know, that kind of spreads. And it gives people hope, excitement, a sense of achievement"*. However, they acknowledged that the perception of the benefits of participating in the LYPS could be harder for staff members working in control teams.

Theme 4: Logistical issues

Theme 4 describes trainers', practitioners', SpoCs', leads' and managers' experiences of logistical issues hindering the implementation of the LYPS. It contains two subthemes: 4a. Issues recruiting young people, and 4b. Difficulty accessing resources.

Subtheme 4a: Issues recruiting young people

Trainers spoke about their services facing challenges recruiting young people for the Your Choice programme: *"There were a handful of people who went through the training that were handed a Your Choice case fairly quickly. But the vast majority of people, they still hadn't been handed a Your Choice case"*. This impacted clinical supervision and training due to practitioners not having active cases or having long periods of time between training and their first Your Choice case. This also meant that when booster training was offered, trainers felt that it was not always delivered at the most effective time: *"The vast majority of people, they still hadn't been handed a Your Choice case. And so, the four-week follow-up really was just not very … it just didn't do anything"*.

SPoCs, leads and managers mentioned struggling to reach recruitment targets for the LYPS: *"We've not found getting participation to be easy"*. Reasons behind this included not having enough throughput of young people at their services, young people moving boroughs, staff not being able to convince young people to take part and young people not wanting to take part or being reluctant to complete the evaluation paperwork: *"We had a batch of young people who were just refusing to do it. And they were basically like, 'I'm not helping you. I'm not helping the system. I'm not helping the council or the police'"*.

SPoCs, leads and managers described trying to 'sell' the LYPS to young people, with some staff being more confident or proactive about this than others: *"The dilemma with the control group is trying to get staff to be persuasive about participating in something in which [the young people are] not actually going to participate"*. Practitioners having an existing relationship with young people prior to recruitment was felt to be helpful when introducing the LYPS: *"We felt that we'd stand a much better chance of then … of getting our young people engaged in the programme if they already had a trusting relationship with … their practitioner"*. Having a budget for young people to engage in activities or to buy young people things that

made a difference in their lives (such as covering travel costs or mobile phone credit) was viewed as a tool for engaging young people with their Your Choice sessions.

Practitioners also described having difficulties recruiting young people to take part in the LYPS. They also felt that the cases referred to their teams were not always those that readily reflected the LYPS inclusion criteria, such as when their teams primarily conducted long-term or family intervention work with young people.

> *"So, parents, it's really hard to get them to sign off in the first place. You know, that takes weeks of cajoling, telephone calls, meetings. Getting them to do the paperwork, getting it back. The children, often in the first instance, aren't madly engaged either because they don't really understand".*

Subtheme 4b: Difficulty accessing resources

Practitioners had not always found it easy to access the budget for activities for young people within the Your Choice programme. Sometimes they had had to wait a long time for funding requests to be approved within their services: *"You feel like you promise them something that's not going to happen because there's, there's a whole problem with our budget at the minute"*. They also did not always feel that they had clarity on what the budget could be spent on: *"That's a whole debate within our team, about what the funding guidance is and what we should be using it for and what amount we should be … it's not clear. It's all very much up for debate"*. Similarly, SPoCs, leads and managers indicated that there was not always consistency or clarity across services in how the budget should be used.

Theme 5: Degree of alignment with existing practice

Theme 5 highlights SPoCs, leads, and managers' and practitioners' perceptions of the extent to which Your Choice reflected or departed from services' or teams' existing practices. It contains two subthemes: 5a. Novelty of Your Choice, 5b. Consideration of young people's ethnic or cultural background.

Subtheme 5a: Novelty of Your Choice

SPoCs, leads and managers described how, where Your Choice reflected or fit with existing practices, it was easier to implement and felt like less of an additional burden to deliver: *"It didn't feel like Your Choice was particularly different to what we were already doing"*. Where Your Choice presented a departure from services' or teams' usual ways of working, it was a harder sell to practitioners to add to their busy workloads. Being able to show what Your Choice added to practitioners' existing resource banks or 'toolboxes' was important from SpoCs', leads' and managers' perspectives: *"CBT just works alongside. And it just, it does give them another tool in their toolbox is what I would say"*.

Practitioners highlighted ways in which Your Choice felt like a continuation of usual practice at their services: *"[Your Choice is] a bit more structured in terms of [there are] worksheets and things to follow. But it's pretty much what we do with them anyway"*. They gave examples of Your Choice activities or conversations that reflected those that they would have anyway at their service as part of their day-to-day work with young people. They mentioned having knowledge of CBT or using CBT techniques in their work prior to Your Choice: *"We were doing a lot of the CBT stuff before even being delivered the training, but we just didn't have a label for it"*.

Practitioners also highlighted ways in which Your Choice differed from usual practice at their services. These included differences in approaches, in terms of taking a systemic approach in usual practice and a CBT

approach in Your Choice: *"You just take the hat off, put on your CBT hat, and when you're done, you put your systemic hat back on"*. The focus on one-to-one sessions and goal setting of Your Choice was also sometimes a departure from practitioners' usual practice.

> *"That's something that maybe is difficult as a practitioner having a different background and a different kind of context, er, to sort of have to work in this one-to-one way. So yeah. That's something that maybe I've had to adjust to a little bit".*

Indeed, with Your Choice incorporating several elements of CBT, trainers felt that practitioners sometimes had anxieties about the training and their capabilities. This was especially true for those who had previously been working with a more systemic approach.

> *"So the resistance was mainly as a result of some feeling, 'We may not be able to manage this. We may not have the capability to do this. It's difficult. We don't think we are capable'. So those fears, I think, were getting [in] the way of the people, and that's why they became anxious".*

The programme was also *"unfamiliar"* and *"unknown"* to practitioners, which trainers felt had initially manifested in more resistance to accepting Your Choice: *"I think, initially, there was a lot of persuading, convincing that needed to occur. It was new. It was a change"*.

Subtheme 5b: Consideration of young people's ethnic or cultural background

Practitioners felt that consideration of young people's ethnic or cultural background was part of their usual work anyway, so this was no different in a Your Choice context: *"I don't feel that Your Choice added anything extra just because that's how we work always, with I think very good awareness of our own bias"*. However, they appreciated that discussions about identity and values (e.g. culture, spirituality) were a formal part of Your Choice. They described how the questions or issues that young people brought to their sessions could vary by their ethnic or cultural background: *"She's brought that to the table, um, and that opened up the culture discussion. I learnt a lot about (nationality) culture... through that one particular young person"*. They also mentioned translating or using an interpreter for sessions and materials when young people or their families could not speak English.

Similarly to practitioners, SPoCs, leads and managers highlighted that consideration of young people's ethnic or cultural backgrounds was part of their usual work anyway, so this was no different in a Your Choice context. However, they also indicated that potentially the influence of young people's ethnic and cultural backgrounds could have been considered more than it had been within their service's implementation of Your Choice: *"I haven't had any direct feedback from practitioners relating to that, and we're not at a point where we've been able to have those reflective conversations sort of on completion"*. For example, there was a suggestion that more consideration could have been given in the training to ethnic or cultural reasons why young people may differ in their engagement with Your Choice: *"I think … if maybe … that was discussed in a bit more detail in the training … then we might be more encouraged … we would be encouraged to pay more attention to it as an issue I think"*. The lack of space that they had within the demands of the LYPS to match young people to a particular practitioner with a specific ethnic or cultural background was also acknowledged: *"We don't have that luxury of choice because we don't have that many young people who meet the criteria"*.

Theme 6: Being part of the evaluation

Theme 6 describes perspectives on being part of the evaluation component of the LYPS.

Practitioners liked the baseline and follow-up review points that the questionnaire completion element of the LYPS had required them to build into their work with their Your Choice cases because this gave their work structure. They suggested that an additional midpoint review would be helpful. They also liked the conversations that completing the questionnaires together with young people had opened up.

> *"He'll still stand by what he says, but I just said to him, like, 'I then have to do my own questionnaire, and I'm possibly going to change, like, not change your answers, but I might do [something] different to you'. And then that opens up those conversations of why my answers might be different".*

However, practitioners also raised issues with the questionnaires. These included the questionnaires being too long for young people with ADHD to complete or the questions about involvement in criminal behaviour being perceived as offensive by young people: *"She refused to give her consent based on this questionnaire"*.

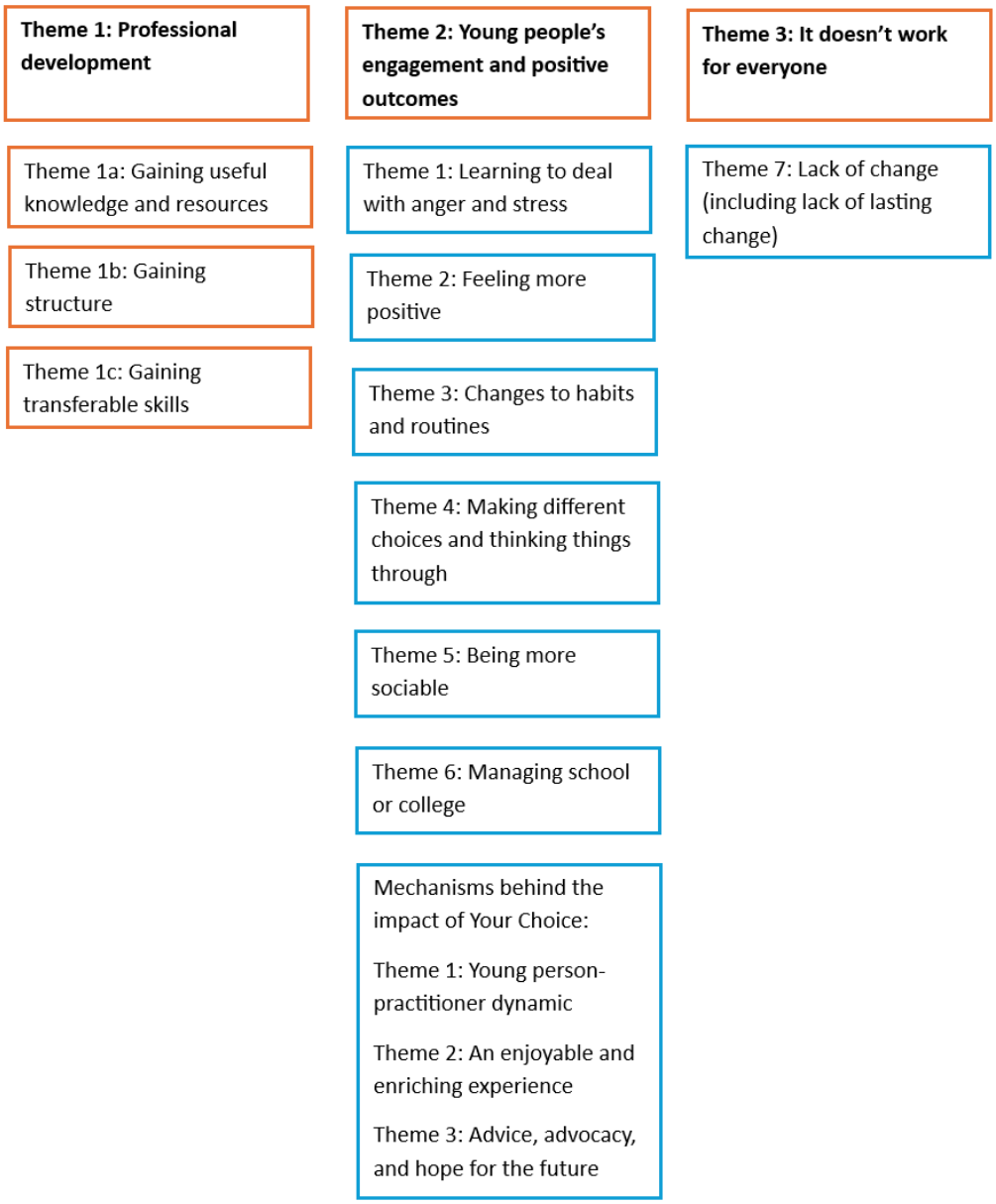
Some practitioners did not mind the process of electronically recording their case and session notes in the LYPS portal, but others found that this was time-consuming and not straightforward: *"I do think the recording for me is probably the most annoying part about it all. It doesn't quite always fit in with the way we work, so it can be a bit of a chore"*. They suggested that the portal could be more streamlined and user-friendly.

Trainers felt that the data collection component of the evaluation had contributed to additional pressure for the practitioners: *"The demands from data and everything can be really overwhelming"*. They highlighted that the *"tick box exercises"* of the evaluation tasks were at odds with the heavy emotional or demanding nature of the work that the practitioners were doing with the young people:

> *"I understand how important the data is. However, the practitioners are working with the most complex young people that we have. Like, they're holding so much. Sometimes, they're like, 'So, this person has been missing for three weeks. I've been calling them every week, I'm doing reports, I'm meeting with the police and you're asking me for a number? Like, are you asking me how many times I called them?'"*

IPE-RQ4. What are young people's and practitioners' views and experiences of Your Choice (acceptability, impacts and mechanisms)?

Figure 9. Summary of the main themes and subthemes for practitioners [orange] and young people [blue] relating to IPE-RQ4 – views and experiences of Your Choice (acceptability, impacts and mechanisms).



Practitioners

Theme 1: Professional development

Theme 1 describes how, for practitioners, the Your Choice programme was an opportunity for professional development. It contains three subthemes: 1a. Gaining useful knowledge and resources, 1b. Gaining structure and 1c. Gaining transferable skills.

Subtheme 1a: Gaining useful knowledge and resources

Practitioners spoke about particular activities from the Your Choice programme that they had liked using or that had worked well with young people, such as social graces, values or the tree of life.

> *"I quite like the social graces activity, I feel like it just puts everything on the table of everything's okay to talk about, and so it can lead to quite an open conversation, and often you might not guess, it might come up with sexuality or religion or education".*

They had found the workbook, worksheets and bank of resources that Your Choice provided helpful for providing guidance and tools for use in sessions: *"All the self-soothing, um, advice that the Your Choice workbook gives them as well, I think is really good"*. They liked the goal setting and CBT threads that ran throughout Your Choice. They described developing their CBT skills through receiving training and delivering the programme.

SPoCs, leads and managers also alluded to the professional development opportunities Your Choice afforded practitioners, such as in terms of giving them new skills and resources to add to their repertoires.

Trainers felt that the training had helped practitioners develop the practical skills needed to support the complex needs and high-risk status of young people engaging with the Your Choice programme. They described this as enabling practitioners to better engage with families and provide support at an earlier stage, potentially avoiding escalation.

> *"They will manage extremely high-risk cases, children with multiple complex needs. But because they have got their skills upskilled, they are better able to engage with families for providing resources at an early age and at an early stage before they escalate to needing, probably, a [highly] intensive, high-cost placement".*

Subtheme 1b. Gaining structure

Practitioners described how the Your Choice programme had brought structure to their work with young people through its time-limited nature and the expectation that, as part of the programme, practitioners would track young people's progress via the LYPS questionnaires and the goal-setting tracker. The workbook and worksheets had also helped them plan and define the focus for each session with young people.

> *"It's just more structured because it feels like we … this is … 'Okay, this week, this is what we're going to be doing'. And they could, like, I could show them that this is what we're going to be trying to work with. This is the worksheet they're going to be focusing on".*

Practitioners saw the structure that Your Choice had brought as being helpful for both them and the young people who they worked with: *"This actually feels really monumental, the fact that like we have a regular structured thing in his life"*.

Your Choice was also seen by SPoCs, leads and managers as bringing structure to practitioners' work with young people through its provision of useful activities, workbooks and resources; its intended three sessions per week framework; and its use of goal setting.

> *"The demand that children get seen three times a week and then, in a sense, that forced our staff to actually make timetables for the child and themselves. You know that, for me, gave them much more structure in terms of how they were working with the child and their family".*

Subtheme 1c. Gaining transferable skills

Practitioners felt that they would continue to use the Your Choice resources and the CBT skills that they had developed through Your Choice in their work with other young people in future: *"Just having access to all of those is really useful, and I would definitely keep using them"*.

Theme 2: Young people's engagement and positive outcomes

Theme 2 describes experiences of working with young people who had engaged well with Your Choice and shown positive outcomes.

From practitioners' perspectives, these were young people whose needs were compatible with the Your Choice model: *"I suppose I feel it works quite well for this young person because I think a lot of it is around personal motivation and how she feels about herself and what she feels she can achieve and low mood"*. Young people had also engaged well with Your Choice when they were ready to make changes, when they were able to identify an activity that they were interested in doing that Your Choice could facilitate or when their goal was to find a hobby. Practitioners also described having established relationships with young people prior to beginning the Your Choice programme, which had facilitated engagement.

Practitioners described their perceptions of the positive impact of the Your Choice programme on the young people with whom they had worked. They had noticed changes in young people's behaviour, reflectiveness, ways of handling situations and communication with family members: *"You could see the benefits because, like I said, there was a reduction in their behaviour points"*. Mechanisms behind change from practitioners' perspectives included young people being able to set and track their goals over the course of the programme, involving family members in sessions and young people building a relationship with their practitioner: *"Having the goal there and seeing the steps that she needed to take, I think that helped her"*.

SPoCs, leads, and managers had also observed positive outcomes for young people who had received Your Choice: "I think the programme itself in terms of the delivery of it has gone well. I feel like we've been able to get some really good outcomes with children".

Theme 3: It doesn't work for everyone

Theme 3 describes practitioners' perspectives that Your Choice was not always the right programme for all young people.

Practitioners described young people disengaging from Your Choice once they had begun taking part in the programme. Reasons for this from practitioners' perspectives included the programme being too much for young people at that time in their lives, young people experiencing disruptions in their wider contexts, young people being mistrustful of the programme or the service and young people not being ready to change or feeling like they did not need help.

> *"You can have a kid that's doing really well, and then over the weekend, they get in trouble, and you're kind of back to square one. So, at times, it can be difficult, or their circumstances totally change, and they're suddenly miles away in a prison or in a placement 150 miles away".*

Young people

Emotional, behavioural and relational change – summary

At time 1 (mid to last stages of receiving Your Choice), young people described a range of emotional and behavioural changes as a result of Your Choice. They described learning to deal with anger and stress and

feeling more positive and less depressed. They discussed changes in their habits and routines as a move from having nothing to do to being more active and engaging in more activities, which had helped to give them a sense of purpose. The Your Choice sessions had helped young people make different choices and think things through, thus reducing their involvement in crime and violence from their perspectives. However, there was a lack of change for some, as not all young people interviewed described emotional, behavioural and relational changes.

At time 2 (approximately six months later), some young people described sustained improvements in emotion regulation and wellbeing and the development of a prosocial identity. However, this was not the case for all young people, and some described the need for further ongoing support for emotional, behavioural and relational changes to occur after Your Choice had ended.

Theme 1: Learning to deal with anger and stress

At Time 1, young people described feeling calmer and learning methods to manage anger, stress and anxiety and to relax. These included breathing, meditation and counting methods.

> *"Sometimes, when I feel my chest getting tight, I be using those breathing exercises. And it just all releases it at once. It just gives you a massive relief. Do you get me? And you just feel better and just feel a bit more free".*

Young people also mentioned their Your Choice practitioners suggesting alternative activities that they could do when they were feeling angry to prevent them from getting into arguments and fights, such as exercising, having a time-out, doing something relaxing or talking to someone else.

> *"She said, like, if you do find yourself, just go take yourself for a walk. Because I live in a flat, so even if it's literally around your flat, just go for a walk. And I've done that quite a couple of times and I found it has helped really well".*

They described being able to recognise and express their emotions better following their Your Choice sessions.

> *"She's just helped me to become more stronger, like, endurance and stuff. Just to like deal with stuff better because back then, I couldn't really deal with anything without getting angry or upset. It helped to recognise those emotions or feelings or whatever".*

Theme 2: Feeling more positive

At Time 1, young people described feeling happier, less depressed and more positive as a result of the changes that had happened through their Your Choice sessions or as a result of enjoying spending time with their Your Choice practitioner.

> *"Back then, I was just very negative and pretty much depressed because [there] was nothing really good going on in my life. But now, I can see the bright side of things and stuff, and I can look forward to it".*

They also described feeling more motivated following their Your Choice sessions: "*There's a lot I can take from it, like the motivation. There was ways to motivate yourself and everything. So, there's a lot I can take back and use them in my everyday life*".

Theme 3: Changes to habits and routines

At time 1, young people mentioned being more active and doing more activities following suggestions from their Your Choice practitioners. This was described as a move away from having nothing to do, which was important, as it had helped to give young people a sense of purpose.

> *"I've been doing stuff; I've been going out. I feel like, back then, I felt less of a person than I do now because I was literally doing nothing with my life except just [lying] at home and [doing] nothing. Now I'm just living life to the fullest pretty much".*

Practitioners had set up exercise activities for young people, such as boxing or the gym: *"She gives me good advice [on] how to do it, and she helps me do it by letting me go boxing. She set it up for me. She set up gym sessions for me"*.

Young people also spoke about making positive changes to their sleeping and eating habits, again on the advice of their Your Choice practitioners, such as having a sleeping and eating schedule.

> *"She has been helping with, like, helping me find a routine and … because I sleep quite late, 1 am, 2 am. Obviously, now I've found a routine that she gave me yesterday. Like, waking up on time, eating normally, eating lunch at school, etc".*

Theme 4: Making different choices and thinking things through

At time 1, young people described reduced involvement in crime and violence from their perspectives through their Your Choice sessions helping them to make different choices by:

- Encouraging them to think before acting and consider the outcome
- Turning them away from criminal situations and helping them understand the consequences of crime: *"It turned me away from those [kinds] of situations at least. Having this is like a deterrent"*
- Helping them to think about alternative courses of action or responses to difficult situations, such as not letting their emotions influence their decision-making, trying not to involve themselves in arguments or fights and walking away: *"He wouldn't tell me it was a bad thing to do, but he would tell me I could have done something better that would have got me in less trouble and stuff"*
- Helping them recognise people who might be a bad influence on their lives: *"I think twice before meeting the wrong people; I think twice about where I'm going"*

Theme 5: Being more sociable

At time 1, young people described being more sociable and less shy or nervous in social situations following their Your Choice sessions: *"I just got a bit more confidence because I was talking to [practitioner], and I was having conversations, so I thought maybe I can try and have conversations with other people"*. Practitioners had also set up social activities for them, which helped them to meet other young people.

> *"It's the fact that she'll sometimes bring me out and then I'd meet other people and then I think that just had like… I don't know, it's just like really hard to explain but I think from there, I just started becoming more sociable pretty much".*

Young people also mentioned arguing less with their parents or siblings at home or being better able to manage arguments: *"When my brother tries starting an argument, I just try and walk away, like I don't hit him back"*.

Theme 6: Managing school or college

At time 1, young people mentioned their Your Choice practitioners helping them with their schoolwork, including helping them structure their work, arranging extra tuition in particular subjects and giving them confidence to put their hand up in class.

> *"Because she was telling me, if I try it and I like it, then she thinks I will be more engaged in my lessons and stuff. And I do agree with her because after I started putting my hand up in class more, then I felt more engaged, and I felt like I knew what I was doing in class as well".*

Young people also described being given advice by their Your Choice practitioners about how to manage disagreements with teachers, not to misbehave in class and to ignore peers who are trying to distract them. They mentioned attending school or college more frequently than they used to.

> *"Like the way I talk to teachers, he used to tell me instead of talking to them in certain ways, he'd tell me other ways to approach this situation, and instead of getting angry at the teacher, like ask to take a minute out or ask for her to give you some space or something like that".*

Theme 7: Lack of change

At time 1, young people had not always noticed much or any change in their lives since they had started working with their Your Choice practitioners: *"I don't think I've learnt much"*. They also noted factors that had hindered their progress towards reaching the goals that they had set in their Your Choice sessions, including contextual circumstances that were outside of their control or their own thoughts and feelings: *"**What's been getting in the way or been challenging?"** "Usually, like, my thoughts. Because I get a bit, like, sad, and I'm just like, 'Oh, I'm not going to do it anymore'".*

Were these emotional and behavioural changes sustained?

At time 2, young people felt that they were still better able to manage their emotions, such as anger and anxiety, following their Your Choice sessions. They mentioned continuing to follow advice from their Your Choice practitioners about this: *"I don't have to keep asking people, 'What should I do if I'm angry?' I just remember what [practitioner] said"*. Young people also described continuing to get in less trouble following their Your Choice sessions, such as due to learning from their practitioners about how to handle situations differently: *"He would tell me how to approach different situations, and now I just use it because I don't get in trouble now as much as I used to in certain situations"*. Young people also mentioned experiencing improvements in their confidence and motivation and trying to maintain healthy sleeping and eating habits following their Your Choice sessions.

At time 2, young people described having a more positive experience at school or college now compared to before their Your Choice sessions began, such as attending more regularly and getting into trouble less often: *"I haven't had any recent detentions and isolations"*. Factors contributing to their more positive experiences at school or college included that they were getting into fewer fights with peers now, they were trying not to get angry with or be rude to teachers, and they were paying attention, engaging more or feeling more focused.

> *"I'm not as rude. How I used to, I'd talk with a lot, and I'd be really rude towards them. And I actually wouldn't be the nicest. I'd shout at them and all of that. But I don't really do that".*

At time 2, young people talked about the ways in which their relationships with their parents or siblings had improved since their Your Choice sessions, including having fewer arguments and communicating with each other more: *"**Can you tell me a bit more about what help she gave you with your mum?" "**She just told me about maybe ways I could communicate with her better"*. Young people also referenced changes in their social relationships following their Your Choice sessions, including arguing less with peers, talking more about their feelings with others and developing their social skills, such as being able to speak in big groups of people: *"If you know how each other feels, then you don't really argue about it because you understand how people are feeling"*.

However, young people had not always experienced lasting positive emotional, behavioural and relational changes after their Your Choice sessions had ended. At time 2, young people sometimes felt that they needed more help, such as to manage ongoing anger and anxiety issues and to further improve their confidence and motivation: *"I need someone to talk to"*. They were also not always still engaging with the hobbies or job opportunities that practitioners had supported them in accessing during their sessions: *"It wasn't a job, it was like a, like a training. Yeah, yeah." "**Right. How's that now, are you still doing that?" "**No, I actually left that because um … so I have really bad social anxiety"*.

Young people had also not always experienced lasting positive changes at school or college since their Your Choice sessions had finished. For example, they reported that they were still having problems with teachers or with their behaviour, or they mentioned that they were no longer attending school or college: *"**Why did you stop going to college?"** "It was too much for me".*

*S*ometimes young people were still experiencing difficulties within their social networks, including getting involved in fights and not agreeing with their Your Choice practitioner's advice regarding their peer relationships: *"I just have to resort to using violence if they use it on me first"*. Moreover, not all young people found that their family relationships improved. This was due, for example, to contextual circumstances beyond their control, which neither they nor their Your Choice practitioner had been able to mitigate: *"There's not really much I can do regarding them"*.

All 12 young people interviewed at time 2 reported that their Your Choice sessions had finished by the time of their time 2 interviews. While some young people were aware of why their sessions had ended, such as because Your Choice was a finite programme, other young people had less awareness that there would be an endpoint, for example feeling that the ending had come out of the blue: *"Since [practitioner] and I stopped talking, there wasn't really any guidance. So I kind of just … I don't know, I kind of just started doing stuff on my own, and then that's how it led to that"*.

Young people's feelings about their sessions ending were also mixed. Some young people were amenable to their sessions ending because they felt that they had experienced improvements as a result of their sessions: *"I think most of the problems I had were covered and sorted while I was with them"*. However, other young people felt sad about their sessions ending and disliked that Your Choice had finished: *"I wish I could still see her". "**And why is that?"** "Because I enjoyed the meetings; because I managed to do things I wanted to do"*. Not all young people agreed with their practitioners' perceptions that they had improved enough to finish their sessions.

Some young people had the opportunity to keep in touch with their practitioners if they needed to after their sessions had ended, which they had welcomed: *"She said I could contact her if I ever need help or anything, and I did"*. However, this happened with varying degrees of success: *"She didn't really respond a lot of the time"*.

Mechanisms behind the impact of Your Choice – summary

At time 1, the young person–practitioner relationship was very important to young people and appeared to be an important contributor to whether Your Choice was seen as helpful (when the relationship was positive) or unhelpful (when the relationship was not positive). Young people found the different leisure activities they had been involved in through Your Choice to be enjoyable and enriching, as was the ability to have sessions in different locations. Young people also identified practitioners providing advice (e.g. about knife awareness), advocating in liaising with family members and professionals, and instilling hope for the future through working towards the young person's goals as helpful aspects of Your Choice. However, some young people found the sessions, activities and resources to be boring and repetitive.

Theme 1: Young person–practitioner dynamic

At time 1, young people felt that they could talk about anything with their Your Choice practitioners: *"I will tell her anything, and I know that I can trust her"*. They described their practitioners as *"nice"*, *"kind"*, *"helpful"* and *"caring"*. They referenced their close relationships or friendships with their practitioners, who they saw as similar to them in terms of age, personality and life experiences: *"Having someone like [practitioner] that you can relate to, it just gives you that open space to kind of just talk"*. They felt listened to and felt that their practitioners explained situations and asked them questions in ways that they understood. A positive young person–practitioner dynamic appeared to help young people hear what practitioners were saying and take on their advice.

> *"[Practitioner] will be like, 'I really understand how you feel like that. But when you look at the situation like this', you know what I'm saying; she kind of makes me understand rather than tell me what I should and shouldn't do".*

However, not all young people at time 1 felt listened to by their Your Choice practitioners or always feel like they could talk about everything with them: *"It just feels like it's just one-sided, like anything she says, I have to do or listen to"*. Young people also did not always want or feel that they needed support from Your Choice: *"She always gives me advice and tries to help me. But I don't really want the help".*

Theme 2: An enjoyable and enriching experience

As well as talking to their Your Choice practitioners, young people at time 1 described enjoying a range of leisure activities that their practitioners had arranged for them either during or outside of sessions: *"I just love being out with [practitioner], and we always do something fun. We either … we're at the quad biking, or we go out on nice times like go-karting or for lunch"*. Examples of leisure activities that young people had participated in through Your Choice included boxing, the gym, football, go-karting, quad biking, paintballing, cooking and crocheting.

Young people mentioned that some of their Your Choice sessions had also taken place in restaurants or cafés, which they liked because it was fun, and they were able to have food and drinks while talking to their practitioners.

> *"She took me to [café] and then it was like, because we was in a different environment, it was better and different as well. So, it wasn't just like boring where you're just in a room talking about stuff. You're actually like outside of school and stuff like that".*

However, some young people at time 1 had found some of the Your Choice activities and resources boring: *"Some Your Choice booklet that she's given me that I have to do, it's ridiculous. It's long"*. Young people also mentioned finding some activities, questions, or subjects in their Your Choice sessions repetitive: *"If someone keeps asking you the same question over and over again and there's nothing truly going on. It just becomes too much, you know what I mean?"*.

Theme 3: Advice, advocacy, and hope for the future

At time 1, young people mentioned getting advice from their Your Choice practitioners about problems at school, at college, at home or with friends. Practitioners also shared knowledge with young people, such as about the law or knife awareness.

> *"Because obviously I've got problems at school, if I was to speak to him about it and obviously I would ask him what advice on what to do, he's the one I go to about them things and obviously he helps me".*

Young people described their practitioners liaising with family members, school staff and other professionals to discuss issues and support needs on their behalf: *"She made meetings with the school and asked them how they can help me better and [told] them stuff they could do"*.

Young people appreciated that their practitioners had given them guidance and help in relation to education and employment, including setting up work experience opportunities, helping them to apply for jobs and apprenticeships, and enrolling them in college. Practitioners had also helped young people to apply for provisional driving licences and passports.

> *"[Practitioner] helped me with my CV, we done my CV; she applied for me and put my email in and stuff, so I get the emails, and then she just took me to the interview, like, with college as well; she literally sorted it all out for me; I didn't even have to do anything".*

IPE-RQ5. What are participants' views on the sustainability of Your Choice?

SPoCs, leads and managers felt that **waiting to see what the findings from the evaluation revealed** in terms of the effectiveness of Your Choice was important. They also felt that **ongoing or refresher training and clinical leadership or support** for the programme would be important if Your Choice continued.

Practitioners felt that they would like to **continue using elements of Your Choice in future**, such as the CBT approaches, goal-setting, resources and activities, and the workbook: *"I will definitely be using some of the stuff that I learned with the young people wherever it fits"*. However, they felt that in terms of delivery, if intensive work was to continue with future cases, they **would need to have a reduction in their caseloads**.

SPoCs, leads and managers similarly mentioned that the tools, resources and CBT techniques provided through Your Choice could continue to be used more widely at the service beyond the funded life of the programme: *"I do think people that have used it have seen the value in using the tools. So, I think they would continue to use the tools going forward"*. However, they also indicated that the delivery and structure of Your Choice would likely vary from its current form.

"I'm certainly not an advocate for it stopping. I think it should be available. I just don't know what it would need to morph into to fit lots of different services and lots of different approaches to working with young people".

Trainers likewise alluded to **flexibility in the delivery of Your Choice** as being important for the sustainability of the programme, in that practitioners will likely continue to apply aspects of it in future that they find useful: *"Everyone works differently, but I think there will definitely be some practitioners who will continue to use certain parts of it because I think they found certain parts of it useful"*.

However, trainers also referenced there being **inconsistencies across boroughs** in terms of Your Choice implementation, which they felt could interfere with the sustainability of Your Choice in the long term: *"It feels as though it's being done in different ways across the boroughs, different approaches. And I think, for anything to really, really work, there needs to be a consistency. There needs to be uniform approach"*.

From trainers' perspectives, practitioners' concerns about the future of Your Choice and if it was *"just another programme that's going to come and go"* had also contributed to their reluctance to engage in the training and its implementation.

Ultimately, SPoCs, leads and managers felt that a **lack of funding would affect implementation**, given that there would not be a budget, for example, to provide activities and opportunities for young people: *"Without the funding, I don't think it will carry on"*. Accessing funding was also a key concern expressed by trainers around the continuation of Your Choice in the future: *"It would completely come down to whether the money is there or not"*.

While practitioners hoped that Your Choice would continue in one form or another, decisions about its continued delivery beyond the life of the LYPS were felt to rest with management and the availability of funding and resources: *"It's got to be very specific buy-in from managers across the different services, and then, somehow, support staff to have time do it. Because it is a little bit extra work; it's not nothing"*.

Limitations of the IPE

Strengths of the IPE include the triangulation of data from supervision records, session records and interviews with a range of stakeholders: young people; practitioners; SPoCs, leads and managers; and trainers. This provided rich and comprehensive evidence on the implementation of Your Choice and the experience of stakeholders on the implementation, barriers and facilitators, and perceived impacts.

On the other hand, the IPE was subject to several limitations that may affect the completeness and interpretation of the findings. We describe them below.

Record keeping

LAs were required to maintain supervision and session records, meaning there was variation in the extent to which LAs adhered to recording requirements. The supervision records included non-unique practitioner identifiers, meaning that it is possible that some duplicate records were included. Practitioners were required to complete session forms for the evaluation, but they also had to maintain their own local electronic record system. This may have meant sessions were recorded in one system and not the other, although a random spot check of 10 practitioners did not identify inconsistencies across our records and the local electronic record system.

Definitions of direct sessions

It is possible that practitioners had different definitions of direct sessions. As mentioned above, some practitioners conceptualised sessions as involving text messages or phone calls, and it is unclear the extent to which practitioners entered these contacts as sessions. This means that it is possible that some of the direct sessions we identified included text messages and phone calls for some practitioners but not others. We identified direct sessions as those involving a young person, their parent/carer or their siblings (or a combination thereof). Separately, attendance was recorded but only for young people. If a direct session involved young people, we included in the IPE analysis only those sessions that had been attended. However, this means that if sessions involved parents/carers or siblings – but not young people – we may have included those where the parents/carers or siblings did not attend. However, the vast majority of sessions included young people, meaning that this is unlikely to have changed the pattern of findings.

Whom we interviewed

There may have been a selection bias in the interviews, meaning that those with a more positive or negative experience of Your Choice were more likely to have been interviewed. Across all stakeholders, a mix of views of Your Choice were provided. However, it should be noted that the interviews with young people tended to include more positive rather than negative views and experiences of Your Choice, suggesting that the young people's interviews may have been affected by selection bias. Furthermore, given the consistency of the theme of practitioners having too high a workload, it is likely that we did not speak to those practitioners who experienced this barrier the most.

Engaging young people

We worked with our peer researcher and YPAG to adapt our interviews with young people to the needs of the cohort of young people included in the study. Still, it is likely we were not successful in enabling all young people to take part in an interview. The interviews with young people tended to be short, and there were some particularly short interviews. There were challenges to engaging some young people during interviews and creating an environment in which they were comfortable speaking. At the same time, we had to balance this with the communication preferences of young people and accept that some young people might express themselves in an interview, albeit with fewer things to say. Indeed, we consulted with young people's practitioners before the interviews on the best ways of engaging them. On balance, it is challenging to determine whether we were unsuccessful in enabling some young people to fully express their views in interviews or whether we were successful, and it is our view on what is an appropriate length of an interview that should be challenged.

Cost information

To report cost, LAs were provided a template following YEF guidance. At the time of writing, cost data had been returned by 23 LAs, but it is highly incomplete, and the numbers we report here are based on only seven LAs that returned cost data that could be compared.

The cost information reported in Tables 23 and 24 refers to the cost of one team of five to seven practitioners implementing Your Choice under a usual caseload. Table 23 reports a breakdown of the costs of staff involved in the implementation of Your Choice, including operational leader/service manager, clinical lead and practitioners. On average, it adds up to £56,000 per team of five to seven practitioners in an LA.

Table 23. Summary of staff data on the cost of implementing Your Choice

Cost category and item	Number of LAs reporting data	Mean
a. Operational leader/service manager		
Additional data and governance activities	6	£1,280
Attendance at operational leads network groups	7	£545
Familiarisation with Your Choice	7	£3,364
Overview of cases and supervision of practitioners	2	£170
b. Clinical lead		
Attendance at clinical leads network groups	5	£787
Delivery of training to practitioners	6	£4,249
Participation in training (delivered by LIIA)	5	£1,151
Provision of clinical supervision to practitioners	7	£10,507
Overview of cases and supervision of practitioners	1	£1,654
Additional data and governance activities	1	£2,648
c. Practitioner		
Attendance at coach network groups	4	£690
Delivery of Your Choice – practitioner preparation ahead of sessions and case recordings	6	£499
Delivery of Your Choice – practitioners' attendance at clinical supervision meetings	7	£5,597
Delivery of Your Choice– conducting sessions with young people (and families/teachers if appropriate) including travel time	7	£16,766
Participation in training (delivered by trainer; unit leader)	7	£3,980
Total		**£55,853**

LA = local authority, LIIA = London Innovation and Improvement Alliance

In addition to staff costs, the implementation of Your Choice also includes material and equipment costs, such as tablets or other devices for practitioners, costs for behavioural activation activities and step-down costs. Overall, these amount to slightly over £11,000, bringing the total cost to approximately £67,000 per team of youth practitioners delivering Your Choice to a cohort of young people.

Table 24. Summary of data on materials and equipment required to implement Your Choice

2. Materials and equipment	Number of LAs reporting data	Mean	Min	Max
Travel costs	2	£978	£756	£1,200
Tablets/devices for practitioners	2	£2,973	£2,600	£3345.28
Behavioural activation funds (engagement activities)	5	£2,140	£825	£4,350
Step-down costs (for young people to continue with interests and sustain programme impact)	2	£5,250	£500	£10,000
Total		**£11,341**		

LA = local authority

Conclusion

Table 25: Key conclusions

The key conclusions presented in the table below are authored by the YEF. The main report is authored by the Evaluators.

Key conclusions
Your Choice demonstrated **a small impact** on reducing self-reported severe conduct problems amongst children. After the programme, children assigned to Your Choice practitioners were very slightly less likely to report severe conduct problems compared to their counterparts who were not assigned to Your Choice practitioners. There is uncertainty surrounding this estimate. This result has **a very low** security rating.
Your Choice showed a small impact on reducing children's self-reported hyperactivity, emotional problems, and peer problems and on improving wellbeing and prosocial identity. It showed a moderate impact on improving children's self-reported emotional self-regulation, social connectedness, and how safe they felt. It showed no impact on children's self-reported prosocial behaviour. Your Choice practitioners perceived that children were less safe. These findings are secondary outcomes that are uncertain and should be treated with more caution.
In the Your Choice group, fewer than 1% of children received 36 or more sessions (the expected number of sessions). 16% of children received no sessions, 47% received 1-9 sessions, and 26% received 10-19 sessions.
Low attendance was caused by a combination of practitioner capacity and the perceived preference of children. Your Choice practitioners reported difficulties fitting three sessions a week into their existing caseloads. Practitioners also questioned whether children needed, or wanted, three weekly sessions.
Children reported mixed reflections on the programme, with some commenting that it supported them to manage emotions, engage with education, and make better choices, while others questioned the impact.

Summary of impact and the IPE findings

Impact and outcomes

Despite being partially consistent with the logic model, the estimated shifts in the primary outcome and most secondary outcomes are small and not statistically significant at conventional levels.

However, the impact findings did offer some suggestion that Your Choice had a moderate impact on improving social connectedness and a low impact on reducing the likelihood young people scored in the high or very high range on the peer relationships difficulties subscale of the SDQ. In interviews, young people described Your Choice as helping them be more sociable and less shy or nervous in social situations. Practitioners also set up social activities for them, which helped them meet other young people. Young people also mentioned arguing less with their parents or siblings at home or being better able to manage arguments.

The impact findings suggest that Your Choice may have had a low impact on improving emotional self-regulation and wellbeing. In interviews, young people described learning to deal with anger and stress and feeling more positive and less depressed. They discussed changes to their habits and routines as a move from having nothing to do to being more active and engaging in more activities, which had helped to give them a sense of purpose. Young people described how their Your Choice sessions had helped them make different choices and think things through, reducing their involvement in crime and violence from their perspectives. This was mirrored in practitioners' reports of outcomes for young people, such as improving their reflectiveness, reactions to situations and behaviour. Overall, based on the interviews with young people and practitioners, there seems to have been a positive move towards developing a prosocial identity. However, there was a lack of change for some, as not all young people interviewed described these emotional and behavioural changes.

Other positive outcomes described by young people in interviews included Your Choice practitioners helping them with their schoolwork and improved attendance at school or college.

In the follow-up interviews, there were mixed reports by young people about whether the above outcomes were sustained. A lack of sustained change – or any change reported in the first set of interviews – was attributed by young people to not having learnt much from the Your Choice sessions, context and circumstances that were outside of their control, challenges with managing their thoughts and feelings, not being able to implement their practitioners' recommendations, and a continuation of the difficulties that were being addressed in Your Choice.

The findings from the interviews presented in this report indicate a range of positive outcomes for practitioners from Your Choice. The professional development Your Choice afforded practitioners was described as an important outcome of the programme by trainers; SPoCs, leads and managers; and practitioners. Practitioners had more knowledge and tools, which they could continue to use beyond Your Choice. Practitioners described the value of supervision in terms of their own emotional regulation about a case and gaining new advice and perspectives.

Fidelity and compliance

The description of training from trainers was in line with the logic model and intervention description of Your Choice. Generally, there were few instances of a lack of training being reported; however, in some interviews, practitioners reported not being trained (or fully trained) before delivering Your Choice. Training data reveals a few practitioners in the control group underwent Your Choice training, though the vast majority did not.

Overall, 159 out of the 569 practitioners (27.9%) in the Your Choice group received three or more supervision sessions, which would be the expected number for monthly supervision over a 12-week intervention. Practitioners in the Your Choice group received significantly more supervision sessions than those in the control group. Still, the control group received 135 sessions, and 23 out of 234 control practitioners (9.8%) received three or more sessions, suggesting some contamination. SPoCS, leads, managers and practitioners reported barriers to supervision, including practitioners not having enough time to attend supervision. Practitioners also highlighted the barriers of a lack of fit between practitioners' and supervisors' schedules and turnover of supervisors. Like the delivery of Your Choice sessions, the delivery of supervision was intended to be tailored to the needs of the local service, suggesting uniformity was not expected.

Young people in the Your Choice groups received an average of 8.1 sessions, significantly more than those in the control group (3.4 sessions on average). Still, only a small number of young people in the Your Choice group (less than 1%) received 36 or more direct sessions, the equivalent of three sessions a week for 12 weeks, while 16% of them received no sessions at all. Nonetheless, a large proportion of Your Choice session types used CBT tools, in line with the logic model and intervention description. Likewise, 'relationships' was another frequent Your Choice session type. Still, 12% of young people in the control group had at least one recorded Your Choice session, suggesting some contamination. It should be noted that CBT was not the only theory on which Your Choice was based, with systemic and trauma theory and network approaches that focus on mentalisation being others.

The requirement for sessions to be delivered three times a week was seen as flexible, with the priority being tailoring support to the individual needs of a young person. Indeed, trainers described it being reflected this way in the Your Choice training of practitioners. Practitioners described their workloads as a barrier to

scheduling three sessions per young person per week. Practitioners' time to deliver Your Choice was a general barrier reported by trainers; SPoCs, leads and managers; and practitioners. This revolved around practitioners having existing caseloads that were already too large and high staff turnover. Both practitioners and young people described young people's views that three sessions a week were too much as a barrier to the intended intensity. Trainers, SPoCs, leads and managers described establishing buy-in from practitioners as an important challenge to overcome. SPoCs, leads, managers and practitioners described establishing buy-in from young people was an important challenge to overcome. Emphasising the flexibility of the programme and the budget for young people were described as facilitators for both practitioners and young people.

Young people described finding Your Choice an enjoyable and enriching experience as a facilitator to engagement; however, some young people found Your Choice sessions less positive and engaging. Your Choice practitioners giving young people advice, providing advocacy for them and helping with activities that gave them hope for the future were described by young people as other facilitators to engagement.

The evidence presented in this report suggests a clear tension between the intended intensity of three sessions a week with young people, outlined in the protocol, and tailoring the delivery of Your Choice to the individual needs of each young person, also outlined in the protocol. This makes it challenging to interpret the number of Your Choice sessions that were delivered. However, tailoring the number of sessions to each young person's needs was not the only reason for not delivering three sessions a week: the very real pressures of practitioners having high caseloads and high levels of turnover in services were commonly reported reasons.

Contextual factors

The findings presented in this report should be considered alongside contextual factors occurring during the course of the evaluation, as highlighted by the central programme delivery team. Due to COVID-19, initial training was provided online, and the programme delivery team noted the benefits of face-to-face training for developing relationships with key LA contacts, which then helped facilitate better engagement throughout the evaluation. The riots following the Southport murders had psychological and physical impacts on young people and the workforce, with an anecdotal report of face-to-face contacts not being able to proceed due to safety concerns. From a programme delivery team perspective, staff motivation and attrition towards the end of the study, when the LAs' funding for Your Choice delivery was nearing an end, also impacted engagement and resulted in staff with experience of Your Choice leaving. Finally, implementing an RCT in LAs and ensuring that the evaluation requirements were being delivered was a challenge, and, at times, the requirements of implementing Your Choice and the evaluation were seen as confusing and conflicting.

The findings of this evaluation should also be considered within the context in which it was conducted. The intention of the programme was to support young people living in complex and challenging contexts with multiple needs. The description of the included sample provided in this report indicates that this is indeed the cohort of young people we included, although it should be noted that many LAs put forward teams they thought would be particularly suited to implement Your Choice in the Home Office pilot, but because these teams were not randomised, they were excluded from the trial.

Limitations of the IPE

Strengths of the IPE include the triangulation of data from supervision records, session records and interviews with a range of stakeholders: young people; practitioners; SPoCs, leads and managers; and trainers. This provided rich and comprehensive evidence on the implementation of Your Choice and the experience of stakeholders on implementation, barriers and facilitators, and perceived impacts.

On the other hand, the IPE of the Your Choice program was subject to several limitations that may affect the completeness and interpretation of its findings. Primary among these was inconsistent record-keeping across LAs, which led to variability in the accuracy of session and supervision records. There was also a potential for data discrepancies due to practitioners using different systems and having varied interpretations of what constituted a direct session (e.g. including phone calls or text messages). Furthermore, the interviews with stakeholders may have been affected by a selection bias, as those with more positive experiences might have been more likely to participate, particularly among young people. We also acknowledge challenges in fully engaging all young people during interviews, resulting in some conversations being particularly short and potentially not capturing the full range of their views and experiences.

Limitations of the impact evaluation and lessons learned

Running a trial and evaluation at this scale presents considerable risks, challenges and pressures on implementation partners, though vast amounts of learning were incorporated between the pilot and efficacy phases.

Trial design and randomisation

The evaluation randomised Your Choice at the team level because individual randomisation was neither feasible nor acceptable. Randomisation at the team level was tested in the pilot trial and was believed to ensure balanced allocation of young people across the treated and control groups because the system was evidenced to largely work at capacity, so young people were allocated to teams with the most spare capacity. The pilot did reveal that other factors could influence how LAs allocated young people across teams and that there was a possibility that subjective choice would be involved. This risk was known when the efficacy trial started, and we aimed to mitigate it through intensified training of practitioners and SPoCs during the efficacy trial. However, given the context, no further monitoring or incentives could be put in place to ensure that LAs would comply with an allocation rule based solely on capacity to ensure the allocation of young people across teams was as good as random.

We believe this to be a reason why we see more imbalance in the characteristics of young people at baseline between the treated and control groups than we would expect if allocation were by chance and, more importantly, a consistent pattern of young people in the treated group who seem to have worse behavioural and emotional difficulties and generally higher risk of harm than young people in the control group.

In the primary and secondary analyses, we addressed this imbalance by controlling for all observed imbalanced characteristics, as well as the baseline outcome. This means that the resulting adjusted mean differences in outcomes identify the effect of a young person being allocated to a Your Choice team, as long as there is no difference in unobservable characteristics of young people that determine their outcomes. Our robustness checks provided reassuring evidence that our set of controls was likely to capture these

unobserved differences and that the effect size we estimated was likely to estimate the causal effect of Your Choice on outcomes.

Moreover, if indeed the intervention group was persistently selected from young people with comparatively worse behavioural and emotional difficulties and if Your Choice had a stronger impact on young people at relatively higher risk, as hypothesized in the logic model, our empirical approach (which controls for the baseline outcome) would tend to over-estimate the impact of Your Choice on reducing conduct problems for the average young person in the target group. The fact that we found an effect size on the primary outcome very close to zero provides some reassurance that Your Choice truly did not have an effect on this outcome, despite the limitations of the design.

Primary outcome measurement

The choice of the primary outcome was based on several considerations, including the fact that it would allow the evaluation to more easily and immediately detect an impact on young people's behaviours than if the primary outcome were chosen to be a measure of offending based on administrative data. However, given the existing stigma around the involvement of young people in the criminal justice system and its impact on young people's sense of self, it may be that young people underreported their conduct problems. If underreporting is more likely in the treatment group (who tend to be disproportionately supported in youth justice service teams), this may bias the estimated impact of Your Choice on the primary outcome.

Analysis in the presence of non-compliance

A small or close-to-zero effect size is also consistent with the evidence on compliance and fidelity and suggests that the programme may not have been delivered at the level of intensity required for the effect on outcomes to be large enough to be detected in the trial. Unfortunately, the analysis that aimed to address non-compliance (IV) yielded results that were too imprecise to draw firm conclusions about whether that might have been the case.

Attrition

Approaching over 2,200 young people and recruiting close to 90% of them over the course of the pilot and efficacy phases remains an impressive achievement, which attests to the continued efforts and commitment of LAs. Data collection at this scale also required immense concerted effort from all LAs and the implementation and evaluation teams. After signing a data-sharing agreement with the evaluation team, each LA completed and submitted a workbook with demographic information about young people on a monthly basis. Baseline survey completion rates reached 89%, despite sensitive information being requested. Among those who completed the baseline survey, endline survey completion was 76%. Overall attrition from randomisation to analysis, however, was 44% due to the fact that survey and LA workbook data was not always filled out entirely, and key variables included in the primary and secondary analyses were missing.

Particular attention was directed towards the control group, addressing issues highlighted during the pilot study to ensure robust data collection from both Your Choice and control group practitioners. Although the effort costs of additional paperwork remained evident among the control teams, targeted outreach and clear communication emphasising the critical role of control groups within the RCT significantly mitigated this concern. This may have contributed to attrition not being particularly selective between the treatment

and control groups or differential based on observable characteristics of the young people. The sample used for the evaluation is thus diverse in terms of gender, ethnicity, age and baseline needs.

Future research and publications

Future analysis will include impacts on arrests, measured in PNC, to measure longitudinal impact. We intend to develop the analysis into a research article intended for submission to a peer-reviewed journal.

References

Footnotes and references

Braun, V., and Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology. 3(2):77–101. https://doi.org/10.1191/1478088706qp063oa

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

Butler, A., Chapman, J., Forman, E., and Beck, A. (2006). The empirical status of cognitive-behavioural therapy: a review of meta-analyses, *Clinical Psychology Review.* 26(1):17–31. https://doi.org/10.1016/j.cpr.2005.07.003

Case, S, and Browning, A (2021). "Child first justice: the research evidence base [Full report]," Loughborough University. https://documents.parliament.qld.gov.au/committees/LASC/2021/YJandOLAB2021/tp-Wegener-22Mar2021.pdf

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

de Chaisemartin, C. and Ramirez-Cuellar, J. (2024). At what level should one cluster standard errors in paired and small-strata experiments? *American Economic Journal: Applied Economics*, 16(1):193–212. https://doi.org/10.1257/app.20210252

Dow, M.G., Kenardy, J.A., Johnston, D.W., Newman, M.G., Taylor, C.B, and Thomson, A. (2007). Prognostic indices with brief and standard CBT for panic disorder: II. Moderators of outcome, *Psychological Medicine*. 37(10):1503–1509. https://doi.org/10.1017/s0033291707000670

Erikson, E. (1968). Youth: identity and crisis. Norton. https://doi.org/10.1126/science.161.3838.257

Essau, C., Olaya, B., Anastassiou-Hadjicharalambous, X., Pauli, G., Gilvarry, C., Bray, D., O'callaghan, J. and Ollendick, T. (2012). Psychometric properties of the Strengths and Difficulties Questionnaire from five European countries, *International Journal of Methods in Psychiatric Research.* 21(3):232–245. https://doi.org/10.1002/mpr.1364

Gaffney, H., Jolliffee, D., and White, H. (2021). "Trauma-informed care: toolkit technical report." Youth Endowment Fund. https://youthendowmentfund.org.uk/wp-content/uploads/2021/12/Trauma-informed-training-and-service-redesign.pdf

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: a research note, *Journal of Child Psychology and Psychiatry. 38*(5):581–586. https://doi.org/10.1111/j.1469-7610.1997.tb01545.x

Goodman, K., Cattan, S., Edbrooke-Childs, J., Gregory, I., and Stapley, E. (2022). "Checkpoint scale." Youth Endowment Fund and The London VRU Young People's Action Group.

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

Huey Jr, S. Park, A., Galan, D., and C. Wang (2023). Culturally responsive cognitive behavioral therapy for ethnically diverse populations, *Annual Review of Clinical Psychology.* 19:51–78. https://doi.org/10.1146/annurev-clinpsy-080921-072750

McConnell, B., and Vera-Hernández, M. (2015). "Going beyond simple sample size calculations: a practitioner's guide," Institute for Fiscal Studies, https://ifs.org.uk/sites/default/files/output_url_files/WP201517_update_Sep15.pdf

Ng Fat, L., Scholes, S., Boniface, S., Mindell J., and Stewart-Brown S. (2017). Evaluating and establishing the national norms for mental well-being using the short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS): findings from the Health Survey for England, *Quality of Life Research.* 26(5):1129–1144. https://doit.org/10.1007/s11136-016-1454-8

Quitangon, G. 2019). Vicarious trauma in clinicians: fostering resilience and preventing burnout," *Psychiatric Times.* 36(7):18–19. https://www.psychiatrictimes.com/view/vicarious-trauma-clinicians-fostering-resilience-and-preventing-burnout

Ritchie, J., and Spencer, L. (1994). "Qualitative data analysis for applied policy research," *In* Bryman, A., and Burgess, B. (eds) *Analyzing Qualitative Data,* Routledge, London, 173-194. https://doi.org/10.4324/9780203413081_chapter_9

Romano, J.P., and Wolf, M. (2016). Efficient computation of adjusted p-values for resampling-based stepdown testing, *Statistics and Probability Letters.* 113:38–40. http://dx.doi.org/10.1016/j.spl.2016.02.012

Spaan, P., van den Boogert, F., Grootendorst-van Mil, N., Hoogendijk, W. and Roza, S. (2023). Screening for disruptive behavior in adolescents at risk using the Strengths and Difficulties Questionnaire, *Journal of Research on Adolescence*. 33(4):1085–1097. https://doi.org/10.1111/jora.12858

Sweeney, A., Clement, S., Filson, B., and Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal.* 21(3):174–192. https://doi.org/10.1108/MHRJ-01-2015-0006

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

Ward, T. and Stewart, C. A. (2003). The treatment of sex offenders: Risk management and good lives. Professional Psychology: Research and Practice, 34(4), 353–360. https://doi.org/10.1037/0735-7028.34.4.353

Wenzel, A. (2021). "The therapeutic relationship," *In* Wenzel, A. (ed.) *Handbook of Cognitive Behavioral Therapy: Overview and Approaches,* pp. 175–203, American Psychological Association. https://doi.org/10.1037/0000218-007

Yao, S., Zhang, C., Zhu, X., Jing, X. McWhinnie, C., and Abela, J. (2009). Measuring adolescent psychopathology: psychometric properties of the self-report Strengths and Difficulties Questionnaire in a sample of Chinese adolescents, *Journal of Adolescent Health* 45:55–62. https://doi.org/10.1016/j.jadohealth.2008.11.006

Yardley, L. (2000). Dilemmas in qualitative health research, Psychology & Health. 15(2):215–228. https://doi.org/10.1080/08870440008400302

Appendix A: List of participating Local Authorities and (randomised) teams that participated in the study

Local Authority	Team
Barking And Dagenham	As Team 1
	Corporate Parenting Team 1
	Corporate Parenting Team 2
	FSS Team 5
	YJS Team 3
	Youth Justice Team 6
Barnet	Early Help
	Youth Justice Service Team
Bexley	Staying Together
	Targeted Youth Support
	Youth Justice Service
Brent	Court Disposal Team 1
	Court Disposal Team 2
	Court Disposal Team 3
	Court Disposal Team 4
	LAC Team 1
	LAC Team 2
	LAC Team 3
	LAC Team 5
	LAC Team 6
Bromley	CLA Team 1
	CLA Team 2
	CLA Team 3
	CLA Team 4
	Safeguarding East
	Safeguarding West
Camden	Youth Justice Service
Croydon	YJS - C team
	YJS - J team
Ealing	Targeted Youth Workers
	Youth Justice Service Team 2
Greenwich	Unit 1
	Unit 2
	Unit 3
	Unit 4
	Unit 5
	Unit 6
	Unit 8
Hackney	Young Hackney North 1
	Young Hackney North 2
	Young Hackney North 3
	Young Hackney South 1
	Young Hackney South 2
	Young Hackney South 3
	Young Hackney South 4

Hammersmith And Fulham	TATYP A Treatment
	TATYP B Control
	TATYP C
Haringey	Assessment Team 5
	Safeguarding Team 1
	Safeguarding Team 4
	Vve
Harrow	ASDT
	Children Looked After Teams X3
Havering	Specialist Safeguarding Team
	Targeted Youth Support Team
Hillingdon	Adolescent Team
	Axis
	LAC/ Leaving Care
Hounslow	Adolescent Support Team
	Youth Justice Team
Islington	Child In Need
	Independent Futures Team
	Integrated Gangs Team
Kensington And Chelsea	TATC B Control
	TATC C Treatment
	TATC D Control
	TATC E
	TATC F
Lambeth	FSCP Team 1
	FSCP Team 11
	FSCP Team 12
	FSCP Team 2
	FSCP Team 4
	FSCP Team 5
	FSCP Team 6
	FSCP Team 7
	FSCP Team 8
	FSCP Team 9
Lewisham	Safer Spaces
	Violence Reduction Team
Merton	Catch-22
	Family Assessment And Intervention 1
	Family Assessment And Intervention 4
	My Futures
	SWIS
Newham	PCEHH Workers
	Stay
	Your Choice Team
Redbridge	Atam Academy
	Caterham High School

	Isaac Newton School
	Loxford Secondary School
	Mayfield School
	New City College
	Oaks Park High School
	Redbridge Alternative Provision
	Seven Kings School
	The Bridge
	Wanstead High
Richmond And Kingston	Project X Kingston
	YJS
Southwark	Keeping Families Together
	Team 4
	Team 5
	Team 7
Sutton	Post Court
	Pre Court / Prevention Team
	Schools Team
Tower Hamlets	Breaking The Cycle
	Edge Of Care
	Youth Justice Service
Waltham Forest	Edge Of Care
	ISS
	Youth At Risk
Wandsworth	Adolescent Social Work Team
	CLA Team 1
	CLA Team 3
	Social Work In Schools
Westminster	TAYP 2 Treatment
	TAYP Control Efficacy
	TAYP1 Efficacy

Appendix B: Recruitment documents

THE LONDON YOUNG PEOPLE STUDY

Information Sheet for Young People

My name is Imran Rasul.

I am a Researcher and Professor.

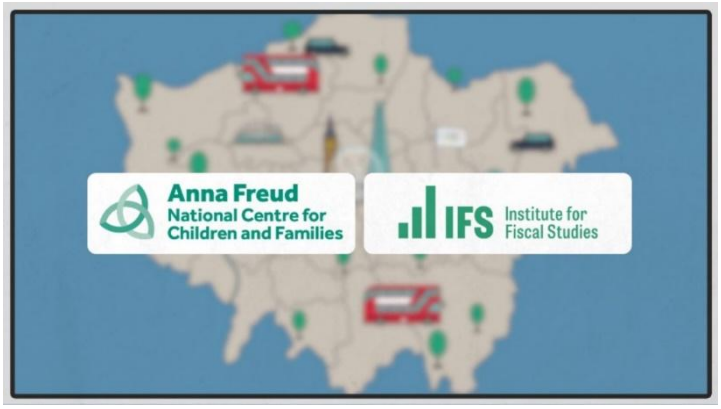
I want to understand **how we can best support young people to keep safe and healthy.**

We would like you to help us.

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

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

Who are we?



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

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

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

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

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

You have been asked to consider taking part in this study because you are:

- Age **11-18 years old** and

- **Currently working with a practitioner** (for example, a youth worker, a social worker or a specialist worker) or a team of practitioners in your area.

Practitioners work with young people in lots of different ways. Some may offer to do different activities and meet with you more often than others. Some receive different training than others.

As part of this study, some practitioners in your area are receiving **new training to help to deliver a new programme. We don't know whether this programme works better** at supporting young people than the usual way of working. This is what we want to **find out in this study**.

To do that, we would like to **invite you to take part in this study**. If you do:

- you will be supported by your practitioner in the way that their team is trained to work with young people
- we will ask you to complete some questionnaires about your feelings and behaviours at the beginning and end of the study.

At the end of the study, we will compare the feelings and behaviours of young people who worked with practitioners who received this new training and those who did not. This will help us learn whether this new programme works better than the usual way of working.

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

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

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

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

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

3 You will work with your practitioner

4 About **four months after**, we will ask you to fill out another **confidential questionnaire about your feelings and behaviours.** If you do, you will receive a **£25 voucher.**

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

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

If you do, you will receive an

- It will be a one-to-one discussion for about 30 minutes.
- It can be online using Microsoft Teams or in person – **it is your choice.**
- If you choose to take part, we will record the discussion so we don't miss what you say.
- *The Transcription Service* will write up what you say - we will make sure they keep your data safe. **We will replace your name with a number and the recording will be deleted.**

Why should I take part in the study?

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

Section 2: Your information and how it will be used

What information will we collect during the study?

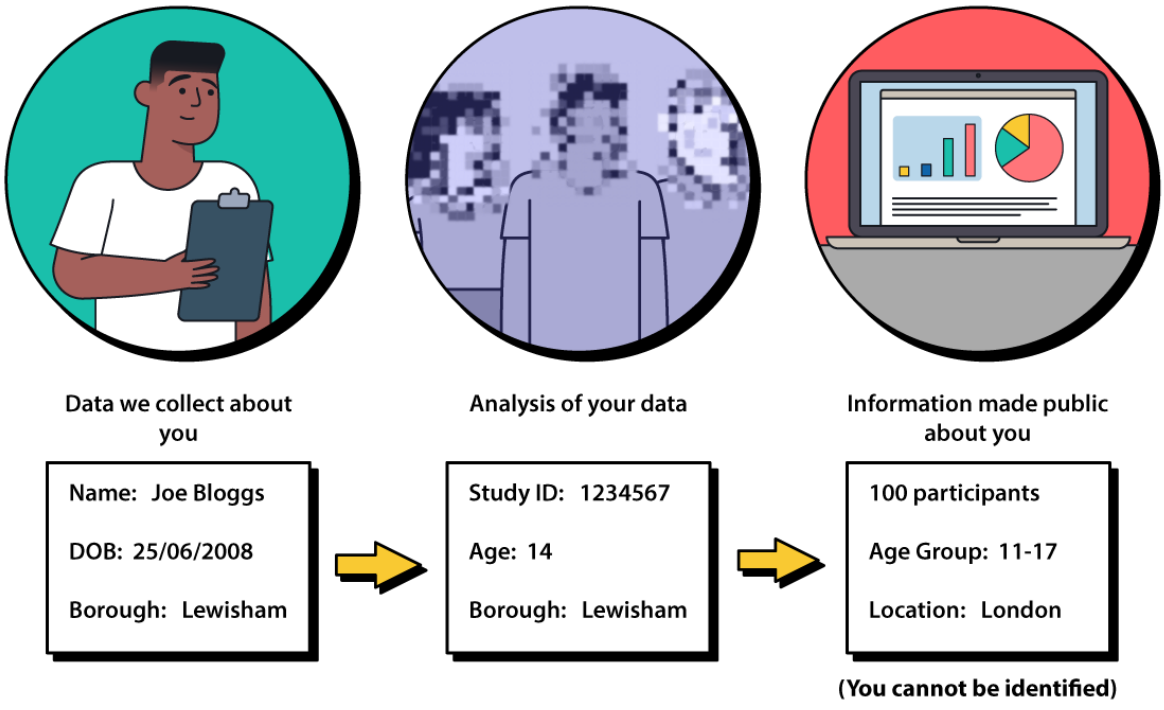
Note: The next section relates to how your information will be used in the study. We would strongly suggest that you go through this with your youth practitioner, and do not

- Your name and contact information in the consent form

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

What will we do with the information that we collect?

- We will use this information to find out **which way works best** for youth practitioner to help young people keep safe and healthy.
    - To help with this, researchers will want to see your progress in the long term and will use information available with the **Department for Education** and the **Ministry of Justice. More information about this can be found in the sections below and in the privacy notice.**
- We will write about the results, **and reports will be free online.** In these reports, we will use the things that you have said but **we will never use your name or any other information that might identify you.** No one will know that it is you who has said them.



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

How will we keep your information safe?

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

- Most of your information is stored by the Institute for Fiscal Studies for the purposes of this project. They will be able to identify you in this information. The Institute for Fiscal Studies has strong measures in place to ensure that only the research team can see your information. Please read more below about requesting to delete this information if you want to.
- The only time someone **other than someone in the research team** will see your name alongside the information you give us in your questionnaire is if we need to share information with your practitioner, **to keep you or someone else safe.**
- If you talk to a researcher about your experience, the recording and write-up (transcript) of the discussion will be stored by the Anna Freud Centre. The recording will be deleted once it has been written up. The Anna Freud Centre has strong measures in place to protect your data and the transcript will be kept for no longer than 9 months.
- After the study ends, some of your information will also be stored in an archive. Your identity is protected by replacing your name and other information with a number.
- There are strong measures in place to protect the information in this archive. This means **you cannot be identified without your information being illegally linked back to your name and address**.
- You can find out more about how we will use your information and who it is shared with in the privacy notice accompanying this information sheet.

What if I want my information to be deleted?

- If you want us to remove your information, you can contact us and ask us to delete them.
- **Your survey responses, which contain your personal information, will be kept by the IFS on an ongoing basis and can be deleted at any time**.
- However, it won't be possible to delete the information which will be stored in the archive because it will not be possible to identify you. Therefore, if you wish for your data to be deleted, you need to do this **before 30th June 2025, when the study ends.**

Section 3: Other information – ethics, questions and complaints

- All research is looked at by an independent group of people, called a "Research Ethics Committee (REC)", to protect your interests and safety.
- **This research has been reviewed and approved by University College London Research Ethics Committee (reference number: 5115/014).**
- If you would like to see a summary of what we will have learned from the study, **please let us know**, or check our study webpage (ifs.org.uk/london-study)
- Please contact us if you have any **questions, problems or complaints** at LondonStudy@ifs.org.uk. Complaints will be dealt on a case-by-case basis following our Complaints Procedure for Research Participants posted on our study webpage
- If you want to take your complaint further, you can contact the Chair of the ethics committee at ethics@ucl.ac.uk

THE LONDON YOUNG PEOPLE STUDY

Information Sheet for Parents of Young People Age 11-15

My name is Imran Rasul.

I am a Researcher and Professor.

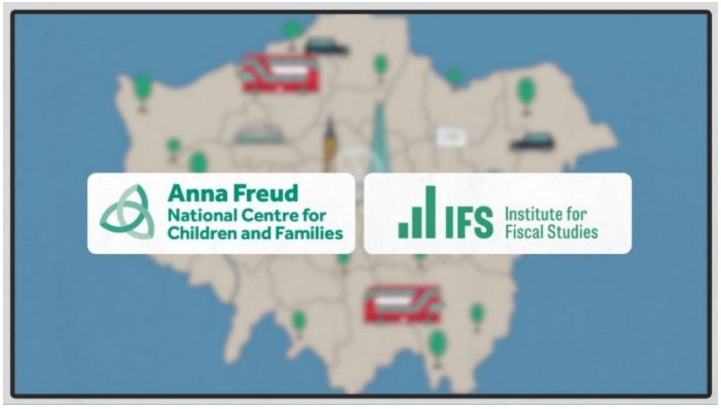
I want to understand **how we can best support young people to keep safe and healthy.**

We would like you to help us.

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

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

Who are we?



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

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

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

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

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

Your child has been asked to consider taking part in this study because they are:

- Age **11-18 years old** and
- **Currently working with a practitioner** (for example, a youth worker, a social worker or a specialist worker) or a team of practitioners in your area.

Practitioners work with young people in lots of different ways. Some may offer to do different activities and meet with you more often than others. Some receive different training than others.

As part of this study, some practitioners in your area are receiving **new training to help to deliver a new programme**. **We don't know whether this programme works better** at supporting young people than the usual way of working. This is what we want to **find out in this study**.

To do that, we would like to **invite your child to take part in this study**. If they do:

- they will be supported by your practitioner in the way that their team is trained to work with young people
- we will ask them to complete some questionnaires about their feelings and behaviours at the beginning and end of the study.

At the end of the study, we will compare the feelings and behaviours of young people who worked with practitioners who received this new training and those who did not. This will help us learn whether this new programme works better than the usual way of working.

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

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

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

1

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

2

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

3

Your child will work with their practitioner

...ks to a researcher about their experience?

...bout 30 minutes

...; or in

...e will

...record the discussion so we don't miss what they say.

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

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

About **four months after**, we will ask your child to fill out another **confidential questionnaire about their feelings and behaviours.**
If they do, they will receive a **£25 voucher.**

5

The Transcription Service will write ... their name ... they say - we will make sure they ... with a number and the recording

Why should your child take part in the study?

- To thank them for completing the questionnaires, they'll receive **Love2Shop vouchers.**
- If they speak with a researcher, they will receive another **Love2Shop voucher**.

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

Section 2: Your information and how it will be used

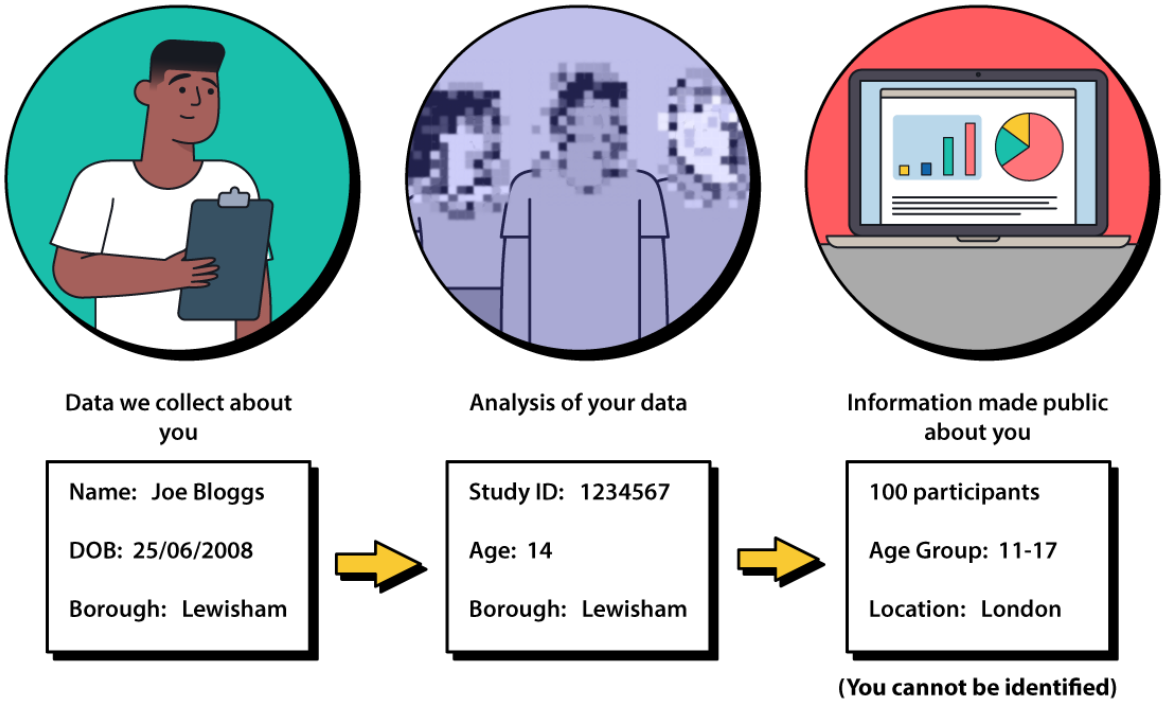
Note: The next section relates to how your and your child's information will be used in the study. We would strongly suggest that you go through this with your child's youth

What information will we collect during the study?

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

What will we do with the information that we collect?

- We will use this information to find out **which way works best** for youth practitioner to help young people keep safe and healthy.
    - To help with this, researchers will want to see your child's progress in the long term and will use information available with the **Department for Education** and the **Ministry of Justice**. **More information on this can be found in the sections below and in the privacy notice.**
- We will write about the results, **and reports will be free online.** In these reports, we will use the things that your child has said but **we will never use your child's name or any other information that might identify them.** No one will know that it is your child who has said them.



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

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

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

- Most of your child's information is stored by the Institute for Fiscal Studies for the purposes of this project. They will be able to identify them in this information. The Institute for Fiscal Studies has strong measures in place to ensure that only the research team can see your information. Please read more below about requesting to delete this information if you want to.
- The only time someone **other than someone in the research team** will see your name alongside the information you give us in your questionnaire is if we need to share information with your practitioner, **to keep you or someone else safe.**
- If you talk to a researcher about your experience, the recording and write-up (transcript) of the discussion will be stored by the Anna Freud Centre. The recording will be deleted once it has been written up. The Anna Freud Centre has strong measures in place to protect their data and the transcript will be kept for no longer than 9 months.

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

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

- If you want us to remove your and/or your child's information, you can contact us and ask us to delete them.
- **Your child's questionnaire responses, which contain their personal information, will be kept by the IFS on an ongoing basis and can be deleted at any time.**
- However, it won't be possible to delete the information which will be stored in the archive because it will not be possible to identify your child. Therefore, if you wish for your child's data to be deleted, you need to do this **before 30th June 2025, when the study ends.**

Section 3: Other information – ethics, questions and complaints

- All research is looked at by an independent group of people, called a "Research Ethics Committee (REC)", to protect your interests and safety.
- **This research has been reviewed and approved by University College London Research Ethics Committee (reference number: 5115/014).**
- If you would like to see a summary of what we will have learned from the study, **please let us know and we will send this to you**, or check our study webpage (ifs.org.uk/london-study)
- Please contact us if you have any **questions, problems or complaints** at LondonStudy@ifs.org.uk. Complaints will be dealt on a case-by-case basis following our Complaints Procedure for Research Participants posted on our study webpage.
- If you want to take your complaint further, you can contact the Chair of the ethics committee at ethics@ucl.ac.uk

THE LONDON YOUNG PEOPLE STUDY

CONSENT FORM FOR YOUNG PEOPLE AGE 11-15

Hello!

We are thrilled that you are interested in taking part in the London Young People Study!

Please complete this form after you have read the Information Sheet and discussed it with your practitioner.

Please read each sentence and tick the box if you agree:

I have read the Information Sheet for this study.	☐
I have had the opportunity to ask questions about the study and how my personal information will be used, and these questions have been answered. I understand what will be involved.	☐
I understand what working with the team supporting me may involve, and I am happy to work with them.	☐
I have enough information to decide whether to participate in the study.	☐
I understand that I am free to stop taking part at any point and can request to have my information removed from the YEF archive until 30th June 2025.	☐
I understand that all personal information will be kept private and stored securely.	☐
I understand that the researchers will link the information they collect on me to my records held by the Department for Education and Ministry of Justice (if any) but neither the Department for Education nor the Ministry of Justice will be able to see my information collected as part of this study.	☐
I understand that I will never be identified in any publications or websites.	☐
I agree to taking part in the above study.	☐

If you would like to have a discussion (which will be recorded) with a researcher about your experience working with your practitioner, please tick this box:

I am happy for researchers to contact me about this	☐

Please enter your contact name, email address and signature below.

First name

Last name

Signature (enter initials if you can’t sign on device)

Local Authority

CYP Case ID

Please be aware, for young people aged 11-15 we also require a completed parent/carer consent form.

THE LONDON YOUNG PEOPLE STUDY

CONSENT FORM FOR PARENTS AND CARERS

Hello!

We are thrilled that you are interested in taking part in the London Young People Study!

Please complete this form after you have read the Information Sheet and discussed it with your practitioner.

Please read each sentence and tick the box if you agree:

I have read the Information Sheet for this study.	☐
I have had the opportunity to ask questions about the study and how my child's personal information will be used, and these questions have been answered. I understand what will be involved.	☐
I understand what working with the team supporting my child may involve, and I am happy for my child to work with them.	☐
I have enough information to decide whether my child should participate in the study.	☐
I understand that my child is free to stop taking part at any point and can request to have their information removed from the YEF archive until 30th June 2025.	☐
I understand that all personal information will be kept private and stored securely.	☐
I understand that the researchers will link the information they collect on my child to records held by the Department for Education and Ministry of Justice on my child (if any) but neither the Department for Education nor the Ministry of Justice will be able to see my child's information collected as part of this study.	☐
I understand that my child will never be identified in any publications or websites.	☐
I agree for my child to take part in the above study.	☐

If you are happy for a researcher to contact you to schedule a discussion (which will be recorded) with your child about their experience working with practitioners, please tick this box:

I am happy for researchers to contact me about this	☐

Please enter your child's details below:

First name

Last name

Date of Birth

Email address

Telephone number

Postcode

Local Authority

CYP Case ID

Please enter your name and contact details.

Parent or carer's first name

Parent or carer's last name

Parent or carer's email address (if different from above)

Parent or carer’s signature (enter initials if you can’t sign on device)

THE LONDON YOUNG PEOPLE STUDY

CONSENT FORM FOR YOUNG PEOPLE AGE 16-18

Hello!

We are thrilled that you are interested in taking part in the London Young People Study!

Please complete this form after you have read the Information Sheet and discussed it with your practitioner.

Please read each sentence and tick the box if you agree:

I have read the Information Sheet for this study.	☐
I have had the opportunity to ask questions about the study and how my personal information will be used, and these questions have been answered. I understand what will be involved.	☐
I understand what working with the team supporting me may involve, and I am happy to work with them.	☐
I have enough information to decide whether to participate in the study.	☐
I understand that I am free to stop taking part at any point and can request to have my information removed from the YEF archive until 30th June 2025.	☐
I understand that all personal information will be kept private and stored securely.	☐
I understand that the researchers will link the information they collect on me to my records held by the Department for Education and Ministry of Justice (if any) but neither the Department for Education nor the Ministry of Justice will be able to see my information collected as part of this study.	☐
I understand that I will never be identified in any publications or websites.	☐
I agree to taking part in the above study.	☐

If you would like to have a discussion (which will be recorded) with a researcher about your experience working with your practitioner, please tick this box:

I am happy for researchers to contact me about this	☐

Please enter your name, contact details and signature below.

First name

Last name

Date of birth

Email address

Telephone number

Postcode

Signature (enter initials if you can’t sign on device)

Local Authority

CYP Case ID

THE LONDON YOUNG PEOPLE STUDY

PRIVACY NOTICE FOR YOUNG PEOPLE

What is a privacy notice?

A privacy notice is an important document which tells you how we use and look after information that we have got about you (or a child in your care).

Who are we?

There are three key organisations involved in the processing and storing of your information. These are the Institute for Fiscal Studies (IFS), the Anna Freud National Centre for Children and Families (AFC) and the Youth Endowment Fund (YEF). Our contact details can be found a the end of this privacy notice.

Who is responsible for looking after the information you have about me?

"Data controller" is a legal phrase, which tells you who makes the decisions about how your information will be used and looked after. During the study, the Institute for Fiscal Studies (IFS) and the Anna Freud Centre (AFC) are what's known as "joint data controllers". This means that IFS and AFC are jointly responsible, for processing and looking after your information whilst the data are being collected and analysed by the team.

When the study is finished in the second half of 2025, your information will be handed over to Youth Endowment Fund (YEF), who have funded the study. This means that YEF will then become another "data controller" along with the Institute for Fiscal Studies who will keep a copy of your personal data for a minimum of ten years. AFC will no longer be a data controller. YEF will store your information in a safe and secure place called the YEF archive. You can find out more about this here (https://youthendowmentfund.org.uk/evaluation-data-archive/), where you can find a copy of their privacy statement.

What information do we collect about you?

The information that we collect, use, store and will share with YEF at the end of the study will include personal information about you. Some of this information will be given to us by you and some of this will be given to us by your youth practitioner.

The information that we will ask you to tell us will include:

- Your name and contact details
- Your parents' name and contact details (if you are 15 or below when you sign up to the study)
- Information about your thoughts, feelings and behaviour that you share with us as part of the questionnaires
- The names and details of your youth practitioners

- The audio recording of your one-to-one discussion with a researcher about your experience in the study if you if you took part in this.

The team that you are working with in your Borough will also share some of the information that they have about you, which will include:

- Your date of birth
- Your gender
- Your sexual orientation
- Whether you are looked after by the local authority
- Whether you have any special educational needs
- Whether you have a disability
- Information about your race or ethnicity
- Whether you are in education, training or employment
- Why you have come to work with your youth practitioner
- The names and other details about other youth practitioners who are supporting you
- When and where you met with your youth practitioners

We will also get some information about you from the Department for Education and the Ministry of Justice which will include:

- Your educational record
- Your social care record
- Your earnings and employment record
- Your crime record (if any)

How do we use your information?

We will use the information you give us to help us to find out how effective the ways in which youth practitioners support young people to stay safe and healthy are relative to each other. This includes how well they have worked in the short term (in the next year) and the long term (in the next few years). By putting your information together with the information about all of the other young people that have taken part in the London Young People study, we will be able to look for patterns that will tell us whether the new way of working is helpful for young people. We will give presentations and write reports about this but this will never include your name or any other personal information about you. The reports will appear on the IFS, AFC and YEF websites.

Who will we share your personal information with?

Your personal data will be collected and processed by the research teams at IFS and AFC.

We will share your information with these organisations:

- Department of Education

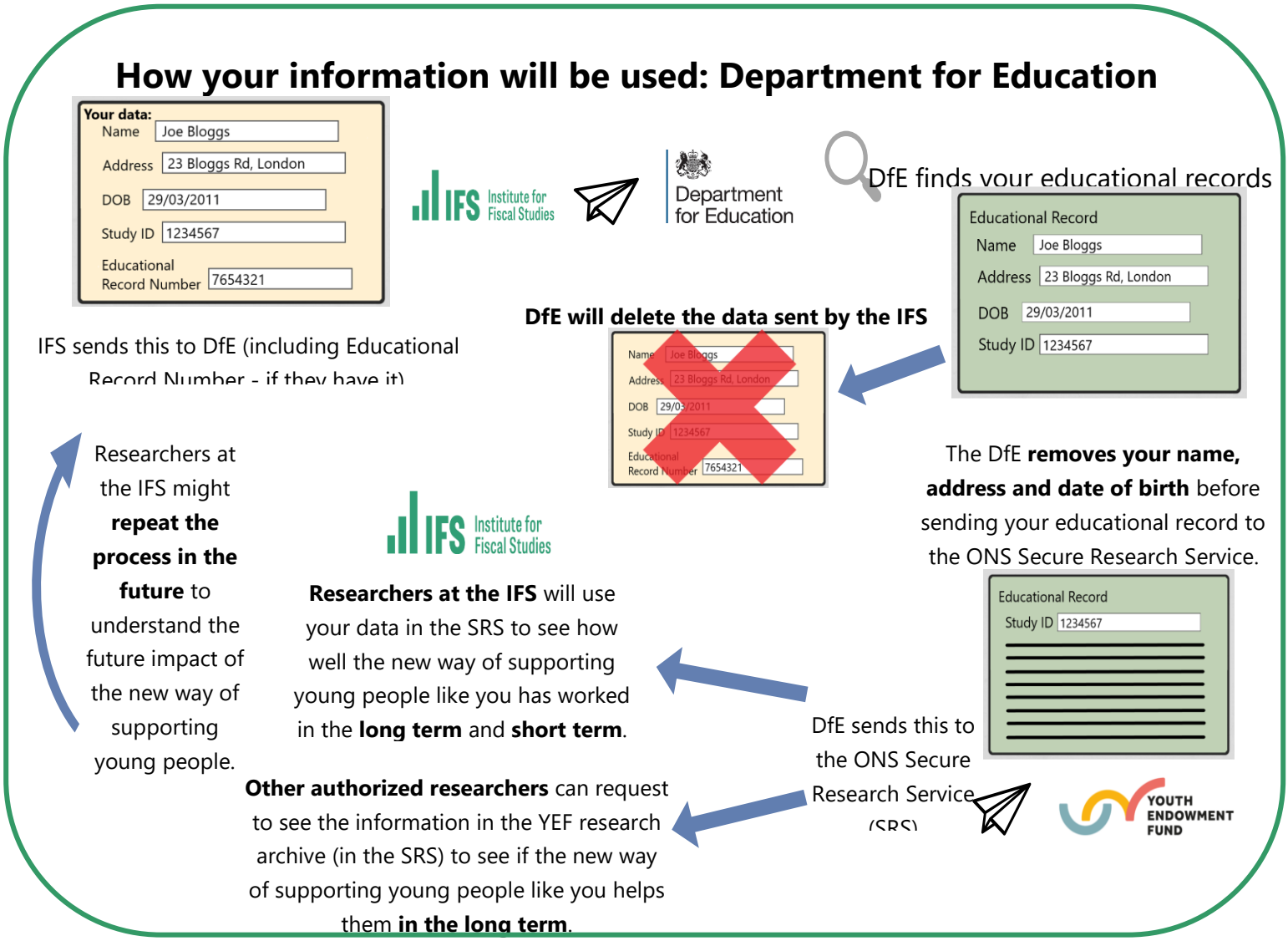
- Youth Endowment Fund
- Ministry of Justice
- The team you work with in your Borough
- The Transcription Service
- Amazon Web Services (AWS)
- Qualtrics

Department of Education and the Youth Endowment Fund

When we have finished collecting data on everyone taking part in the study, we will send your name, address and date of birth to the Department for Education (DfE) and ask them to find your information in their databases. We will not send them your questionnaire answers but we will send them a number in place of your name (study code) so we can find your answers again when they send us their information. If your Local Authority has given it to us, we will also send DfE your educational record number to help them find the right person.

DfE will send your educational records, any social care records, your study code and their own meaningless code to the Office for National Statistics' Secure Research Service where it will be analysed by the research team at IFS. When the study has ended and the research team has completed their analysis, the data used by the research team will be moved to the YEF archive for other approved researchers to use. At this point, the YEF will become another data controller of your data. The YEF archive is part of the ONS Secure Research Service. The Secure Research Service is what is known as a "Trusted Research Environment" which is designed to allow approved researchers to use data safely and securely in their work. All the data in the Secure Research Service is "pseudonymised". This is a term used in data protection that means that you cannot be identified in the data unless the study code given to you is linked back to your name and

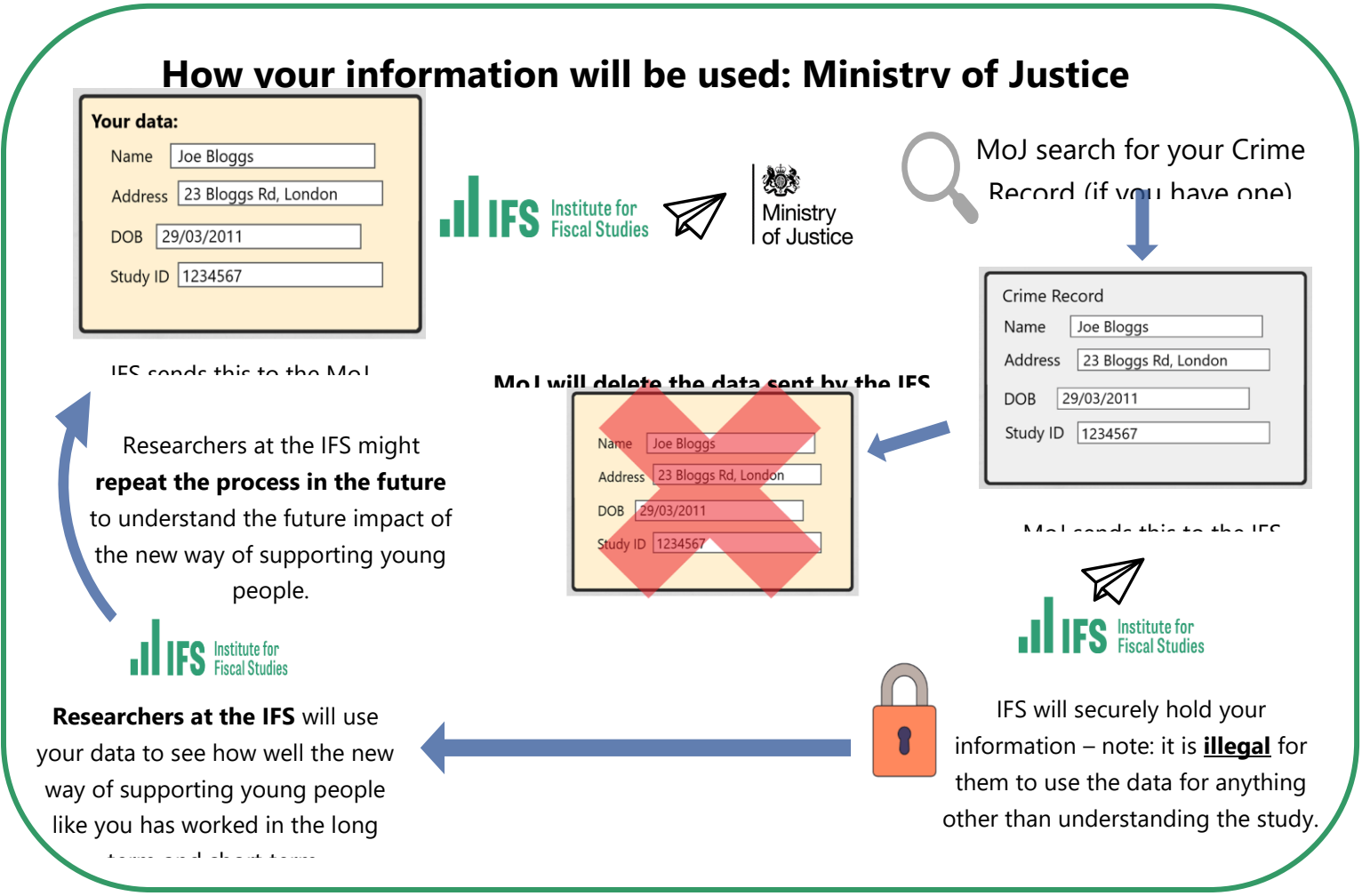
address. Because the Secure Research Service is an extremely controlled environment, it would be technically almost impossible and also illegal for anyone to do this.



The picture below explains how this process works:

Ministry of Justice

When we have finished collecting data, we will send your name, address and date of birth to the Ministry of Justice (MoJ) and ask them to find your information in their databases. We will not send them your questionnaire answers but we will send them a number in place of your name (study code) so we can find your answers again when they send us their information. MoJ will send your study code and your crime records (if you have any) back to the research team at IFS. IFS will store your crime data separately from your name and address to keep your data as secure as possible. IFS will only ever use your data for finding out how well the different services are doing at keeping you safe and healthy. Under data protection law it is illegal for IFS to use this data for any other purpose.



This picture explains how this process works:

The team you work with in your Borough

If you agree to take part in the study, we will ask you (and your parent if you are 11-15) and your practitioner to complete a series of online forms. This includes your consent form (and your parent, if you are 11-15), your baseline and endline questionnaire, as well as a questionnaire to your practitioner at the beginning and end of your work with them. We will also ask the practitioner(s) you work with to tell us when and where you met and some brief information about what work you did together. In order to ensure that all our records are accurate we will share information on which forms you or your parents have completed with the team you are working with in your Borough so that if any forms are missing, the team can ensure that everything we need from you has been completed. We will not share any of the content of your and your practitioner's questionnaire with your Borough. The only exception is if we need to share information with the team you are working with to keep you or someone else safe. When you complete the questionnaire, we will highlight questions that will mean we will need to let the team your working with know if your answer indicates that there is a risk of significant harm to you or other people.

The Transcription Service

As part of the study we are inviting you to talk to a researcher about your experience in the study. If you choose to do this, your audio recordings will be shared with a company called *The Transcription Service* for the purposes of writing up your spoken answers into words. We will make sure that they keep your data safe in line with UK data protection law. When the recording has been written up, we will replace your name with a number and the recording will be deleted.

Qualtrics

We will use a company called Qualtrics to collect and store your survey answers. Details of security standards that Qualtrics holds can be found here: https://www.qualtrics.com/support/survey-platform/getting-started/data-protection-privacy/. Qualtrics will not access your information.

Amazon Web Services (AWS)

Some of your information will be collected and stored using a website-based application (an "app") which has been specifically designed for this project. This app will be used to manage the study and make sure we have recorded your contact details and your agreement to take part. It will not be used to store your survey answers.

We will use Amazon Web Services (AWS) to host this app. Details of security standards that AWS hold can be found here: https://aws.amazon.com/compliance/iso-certified/. Your information will be stored on a server based in the UK or EU. AWS will not access your information.

What does the law say about using and storing my information?

The law says that each data controller must have a "lawful basis" for processing and storing your information in the way that we have described.

IFS and AFC's legal basis for processing information and in this study is *Legitimate Interest*. Our legitimate interest is research into the best way to support young people.

By maintaining the YEF archive and allowing approved researchers to access the information in the archive, the YEF is performing a task in the public interest and this gives the YEF a lawful basis to use personal information.

Certain bits of information about you are known as "Special Category Data" and require more legal protection. This includes things like your ethnicity and wellbeing. This kind of information needs an extra condition for processing. The condition that applies to your data in this study is Article 9 (2) (j) Archiving, research and statistics.

Your crime records (if you have any) also require more legal protection. We process your crime record data under Article 10 and the condition for processing that applies in this study is Research.

How long do we keep your information for?

The information from audio recordings (if you agree to meet with one of the researchers to talk about your experiences in the study) will be kept for no longer than 9 months. As soon as the audio recordings have been written up in text your personal information will be deleted and it will not be possible to identify you.

The information stored by IFS which includes the information that you share in your questionnaires and any crime records from MoJ will be stored for as long as necessary to understand what all of the information, collected together, tells us about the different ways of working with young people. The project will start in August 2023. Your information will then be stored for a minimum of 10 years. This is to allow us time to look at the longer-term effects. After 10 years, we will carry out a review to see if there is still useful work that can be done using your data. At any point that we no longer need your data for this research project, we will delete it.

The coded data (pseudonymised) data that would make it really difficult to identify you by name) that is stored in the ONS Secure Research Service for analysis by IFS researchers will be stored securely for a minimum of 10 years or until the DfE ask us to delete it (whichever is sooner).

The coded data that is stored in the YEF archives at the ONS Secure Research Service will be stored indefinitely to allow for long term follow up. However, YEF will review this every five years to decide whether the information could still be helpful in future research. If it is not, then the information will be deleted.

Your rights

You have the right to:

• ask for access to the personal information that we hold about you;

• ask us to correct any personal information that we hold about you which is incorrect, incomplete or inaccurate.

In certain circumstances, you also have the right to:

• ask us to erase the personal information where there is no good reason for us continuing to hold it – please read the information below about the time limits for requesting deletion of your personal information;

• object to us using the personal information for public interest purposes;

• ask us to restrict or suspend the use of the personal information, for example, if you want us to establish its accuracy or our reasons for using it.

Time limits for deleting your data

Your survey responses, which contain your personal information, will be kept by the IFS on an ongoing basis and can be deleted any time. However, once your name and other identifying information has been deleted from your survey answers and has gone to the ONS Secure Research Service for analysis by IFS researchers or into the YEF archive for use by other researchers it won't be possible to delete your information from those archives because we won't be able to identify

you. If you wish your data to be deleted before it is sent to the YEF archive for analysis by other researchers, you need to do this before 30th June 2025, when the study ends.

If you wish to exercise your rights, please contact us on LondonStudy@ifs.org.uk.

Who can I speak to if I have any questions?

You can contact both the Institute for Fiscal Studies (IFS) and the Anna Freud Centre (AFC) by emailing LondonStudy@ifs.org.uk;

Other contact details

You can find information and other contact details of each of the data controllers on their webpages:

Institute for Fiscal Studies: www.ifs.org.uk

Anna Freud Centre: https://www.annafreud.org/

Youth Endowment Fund: https://youthendowmentfund.org.uk/

Who can I speak to if I want to make a complaint?

If you want to make a complaint about our use of personal data, please contact the Data Protection Officer at mailto:dataprotectionofficer@ifs.org.uk. Complaints will be dealt with on a case-by-case basis following our Complaints Procedure for Young People.

You can also make a complaint to the Information Commissioner's Office (ICO) (The UK's data protection regulator) via;

- their website https://ico.org.uk
- by phone 03031231113
- or by writing to Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF

Appendix C: Checkpoint scale (Goodman et al., 2022)

In this set of questions, we would like to ask you **how likely you think different situations will happen in the next month**.

Your responses are confidential – we will not tell anyone (e.g. your youth worker, the police) what you tell us.

The only exception is if there is a risk of significant harm to you or other people. For questions marked with ** if you answer likely or very likely then we will let your practitioner know so that they can work with you towards a plan to keep you safe.

If you have questions about this, please pause to talk to your practitioner.

In the next month, how likely do you think you are to engage in behaviour that…

	Very unlikely	**Unlikely**	**Neither likely nor unlikely**	**Likely**	**Very likely**
… could cause distress or damage in a public place? (e.g. graffiti or other damage to public property, being drunk in a public place, transport fare dodging)					
… would get you into trouble with the police? (e.g. theft, fire setting, selling illegal substances or property, drink or drug driving, taking a car without consent, carrying an item that could cause serious physical harm to others)					
… could physically hurt other people? ** (e.g. serious physical fights, using an item that could cause serious physical harm to others)					

In the next month, how likely do you think it is that…

	Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely
… that other people in your life will try and involve you in any of the above behaviours? **					

In the next month, how likely do you think it is that you will …

	Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely
… witness a violent crime?					
… be a victim of a violent crime? **					

Appendix D. Effect sizes measured as Cohen's d for primary and secondary outcomes

Outcome	Cohen's d			
	Estimate	[95% CI]	p-value	p-value adjusted for MHT
Primary outcome				
Conduct problems high/v high range	-0.020	[-0.157, 0.116]	0.762	
Secondary outcomes				
Hyperactivity high/v high range	-0.084	[-0.218, 0.051]	0.213	0.940
Hyperactivity score	-0.027	[-0.171, 0.116]	0.698	0.531
Emotional problems high/v high range	-0.029	[-0.158, 0.099]	0.642	0.866
Emotional problems score	-0.067	[-0.228, 0.095]	0.407	0.940
Peer problems high/v high range	-0.157	[-0.327, 0.013]	0.070	0.866
Peer problems score	-0.076	[-0.255, 0.103]	0.392	0.148
Prosocial behaviours low/v low range	-0.002	[-0.186, 0.181]	0.982	0.940
Prosocial behaviours score	-0.016	[-0.179, 0.146]	0.840	0.980
Perceived risk to safety (self report)	-0.130	[-0.323, 0.064]	0.180	0.475
Perceived risk to safety (practitioner report)	0.092	[-0.199, 0.383]	0.524	0.910
Social connectedness score	0.155	[0.034, 0.277]	0.014	0.024
Prosocial identity score	0.048	[-0.121, 0.217]	0.568	0.932
Wellbeing score	0.062	[-0.105, 0.230]	0.453	0.878
Emotional self-regulation score	0.152	[-0.089, 0.393]	0.208	0.531

Note: This table reports effect sizes measured as Cohen's d, which we compute as adjusted mean differences standardised by the standard deviation of the pooled sample for comparability with other trials (see section "Estimation of effect sizes"). The column "Estimate" reports the Cohen's d. The next column reports the 95% Confidence interval. The next column reports the p-value of a t-test of the null hypothesis that this Cohen's d is equal to 0. The last column reports the p-value of this t-test adjusting for multiple hypothesis testing across all secondary outcomes, using the method of Romano and Wolf (2016).

Appendix E. YEF Security Rating

Rating	Design	MDES Outcome: Threshold*	Attrition	Initial score		Adjustments		Final score
5	Randomised design	Offending: <=0.1 SDQ tot: <= 0.3 Other: <= 0.2	0-10%	5				
4	Design for comparison that considers some type of selection on unobservable characteristics (e.g. RDD, Diff-in-Diffs, Matched Diff-in-Diffs)	Offending: 0.11 – 0.19 SDQ tot: 0.31 – 0.39 Other: 0.21 – 0.29	11-20%					
3	Design for comparison that considers selection on all relevant observable confounders (e.g. Matching or Regression Analysis with variables descriptive of the selection mechanism)	Offending: 0.2 – 0.29 SDQ tot: 0.4 – 0.49 Other: 0.3 – 0.39	21-30%					
2	Design for comparison that considers selection only on some relevant confounders	Offending: 0.3 – 0.39 SDQ tot: 0.5 – 0.59 Other: 0.4 – 0.49	31-40%					
1	Design for comparison that does not consider selection on any relevant confounders	Offending: 0.4 – 0.49 SDQ tot: 0.6 – 0.69	41-50%					1

		Other: 0.5 – 0.59						
0	No comparator	Offending: >= 0.5 SDQ tot: >= 0.7 Other: >= 0.6	>50%					

*MDES requirements vary by outcome measurement. Offending: Offending data collected through self-report or admin data; SDQ tot = SDQ total difficulties score; Other: all other outcomes, incl. SDQ externalising and internalising