

Trauma-Informed Training and Service Redesign

Toolkit technical report

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About National Children's Bureau

This report has been produced by the National Children's Bureau on behalf of the Youth Endowment Fund. The National Children's Bureau works collaboratively across the issues affecting children to influence policy and get services working together to deliver a better childhood. They were commissioned by the Youth Endowment Fund (YEF) as their Toolkit Partner 2023–2026. The Toolkit partnership is managed on behalf of NCB by Dr Ciara Keenan and Dr Ella James-Brabham. Any queries relating to the methods should be directed to ckeenan@ncb.org.uk or ejamesbrabham@ncb.org.uk.

About Youth Endowment Fund

The Youth Endowment Fund's mission is to prevent children and young people becoming involved in violence. They do this by finding out what works and building a movement to put this knowledge into practice. The fund was established in March 2019 by children's charity Impetus, with a £200m endowment and ten-year mandate from the Home Office. For more information, please visit www.youthendowmentfund.org.uk.

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Abstract/Plain Language Summary

The primary objective of this report is to evaluate the evidence regarding the effectiveness of **Trauma-Informed Training and Service Redesign** as an approach to prevent violence, crime and offending among children and young people.

Trauma-Informed (TI) Training and Service Redesign are components of TI Practice (TIP), which aims to embed an understanding of trauma into how services are designed, delivered, and experienced.^{1,2} TI Training aims to improve professionals knowledge, confidence, and skills by increasing understanding of the impact of trauma; supporting practitioners to recognise trauma-related indicators; supporting professionals to respond to trauma in a safe and sensitive way; reducing practices that may lead to re-traumatisation; and increasing awareness of secondary trauma among practitioners.^{1,3,4} Service redesign refers to organisational and system-level changes that aim to embed TI principles into service delivery, such as changes to policies, procedures, referral pathways, environments, supervision, and multi-agency working.⁵

TI Training and Service Redesign may be delivered alongside wider activities such as reflective practice, staff wellbeing support, changes to policies and procedures, and clearer referral pathways to specialist support.^{4,6} These approaches are commonly delivered in settings that work with children and young people who may be affected by trauma or at risk of involvement in violence, crime, or offending, including schools, youth services, community organisations, social care, policing, and youth justice settings.^{2,3}

The report includes four studies examining the impact of TI Training and Service Redesign on 124 violence and broader child-related outcomes, and five studies examining 22 professional-related outcomes. Fourteen studies provide insights into how TI Training and Service Redesign approaches were implemented.

Key findings

- TI Training and Service Redesign approaches reduce violence outcomes by 6% based on a meta-analysis of 22 outcomes from 4 effectiveness studies. There is an overall evidence security rating of Level 3 (Moderate) for this finding.
- Across all child-related outcomes, there is no evidence that TI Training and Service Redesign approaches have an effect ($g=-0.01$). This was based on a meta-analysis of 124 measured outcomes across 4 effectiveness studies. There is an overall evidence security rating of Level 3 (Moderate) for this finding.
- Across all professional- related outcomes, there is no evidence that TI Training and Service Redesign approaches have an effect ($g=-0.06$). This was based on a meta-analysis of 22 measured outcomes across 5 studies. There is an overall evidence security rating of Level 3 (Moderate) for this finding.
- Across 14 studies examining the implementation of TI Training and Service Redesign approaches, interventions were generally delivered as intended, with high uptake of key components, alongside strong alignment with TI models, despite some variation in local delivery.
- TI Training and Service Redesign programmes supported a shift toward relational, needs-led, and TI practice, with practitioners embedding these approaches in everyday interactions and decision making.
- Reflective supervision, leadership, and shared frameworks strengthened implementation, while workforce pressures, organisational demands, and system misalignment constrained consistency and sustainability.
- While approaches reached vulnerable and underserved populations, they showed limited systematic adaptation to address structural inequalities (e.g. ethnicity, gender), with some underrepresentation of Black and Global Majority groups, highlighting the need for more explicit equity-focused design.

- Delivery was most effective when relational^a, flexible, and sustained over time, but was limited by workforce capacity and wider system constraints.
- Although costs of implementing TI approaches varied in terms of both set-up and overall expenditure, none of the studies evaluated cost-effectiveness or value for money.

Conclusion

Our systematic review and meta-analyses of finds that TI Training and Service Redesign approaches show a small reduction in violence outcomes but have no effect across child-related outcomes overall, or professional outcomes. TI Training and Service Redesign approaches are most effectively implemented when delivered through relational, flexible, and well-supported approaches, underpinned by strong leadership, reflective supervision, and sustained workforce development. However, organisational constraints, workforce pressures, and limited attention to equity and long-term sustainability continue to shape variability in implementation and hinder consistent system-wide embedding.

^a In this context, and throughout the report, relational refers to approaches that prioritise building trusting and supportive relationships between practitioners and the people they work with.

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List of Abbreviations

ACE	Adverse Childhood Experiences
ARC	Attachment Regulation, Competency
CAMHS	Child and Mental Health Services
CI	Confidence Interval
CNS	Complex Needs Service
C-SPA	Children's Single Point of Access
CYP	Children and Young People
ECM	Enhanced Case Management
EGM	Evidence and Gap Map
FACTS	Forensic Adolescent Consultation and Treatment Service
FfIC	Framework for Integrated Care
IMD	Index of Multiple Deprivation
MASH	Multiagency Safeguarding Hubs
MGDAS	More Good Days At School
ML	Maximum Likelihood
NHS	National Health Service
PACE	Playfulness, Acceptance, Curiosity and Empathy
RBt	Relationship Building Together
RCT	Randomised Controlled Trial
RVE	Robust Variance Estimation
SDQ	Strengths and Difficulties Questionnaire
SEND	Special Educational Needs and/or Disabilities
SMD	Standardised Mean Difference
TI	Trauma-Informed
TIC	Trauma-Informed Care
TIP	Trauma-Informed Practice
TIPs	Trauma-Informed Practitioners
TISUK	Trauma Informed Schools UK
TRM	Trauma Recovery Model
UK	United Kingdom



USA	United States of America
VRU	Violence Reduction Unit
YEF	Youth Endowment Fund
YEF-EQA	Youth Endowment Fund Evidence Quality Assessment

Preface on Terminology

This review draws on evidence spanning over half a century, during which language around personal characteristics has evolved significantly. At times, we may have to reproduce original terminology used in studies which we recognise today as being outdated and unacceptable offensive terms. This only occurs when the terminology is used in direct quotations or refers to an outcome that the author measured that remains relevant to our analysis. The wider narrative will adhere to current inclusive-language standards guided by the National Children's Bureau, Youth Endowment Fund, and Race Equality Foundation. The team acknowledges limitations in terminology and strives for respectful and precise representation throughout. The full preface on terminology can be accessed [here](#).

Objective and Approach

The objective of this report is to review the evidence on the effectiveness of **Trauma- Informed Training and Service Redesign** in reducing and/or preventing violence and offending involving children and young people.

Trauma- Informed (TI) Training and Service Redesign are key components of Trauma- Informed Practice (TIP), which is a whole-organisation or system-level approach that aims to embed an understanding of trauma and its impacts into how services are designed, delivered, and experienced.¹ TIP aims to recognise the prevalence and impact of trauma and reduce the risk of re-traumatisation by integrating trauma awareness into organisational culture, policies, and practices.^{1,2,6}

TI Training plays an important role in facilitating the implementation of TIP and is often the initial stage of organisational change. It aims to develop practitioners' knowledge, confidence, and skills by improving understanding of the impacts of trauma on development and behaviour; supporting the identification of trauma-related indicators; promoting safe and sensitive responses to children and young people; reducing the use of practices that may re-traumatise; and increasing awareness of secondary trauma among staff.^{2,7,8}

TI Training and Service Redesign are typically delivered alongside wider organisational activities, including reflective practice, staff wellbeing support, revisions to policies and procedures, and improvements to referral pathways and access to specialist support.⁷ These approaches are implemented across a range of settings working with children and young people who may have experienced trauma or be at risk of involvement in violence or offending, including schools, youth services, social care, healthcare, community organisations, policing, and youth justice services.^{3,7}

TIP is grounded in evidence that exposure to trauma, such as through adverse childhood experiences, can disrupt neurodevelopment and is associated with differences in emotional regulation, executive functioning, and stress responses.^{9–}

¹² These developmental impacts are linked to increased vulnerability to behavioural difficulties and involvement in violence and offending.¹³

There are several pathways through which TI Training and Service Redesign may contribute to reductions in violence and offending among children and young people. These include improving practitioner understanding of trauma, which may promote more empathetic and less punitive responses;⁶; reducing the likelihood of re-traumatisation through more supportive interactions;^{1,6,14} enhancing recognition of trauma-related needs and facilitating access to appropriate support; and supporting system-wide cultural change that creates safer, more predictable, and supportive environments.^{15,16}

This systematic review and meta-analysis focuses on TI Training and Service Redesign as components of trauma-informed practice within services working with children and young people aged 0–17 years.

This technical report presents findings from a comprehensive systematic review, including:

- **Five effectiveness studies** eligible for inclusion in the meta-analysis.
- **Four UK-based studies** contributed child outcome data, providing:
 - 22 violence-related outcomes; and
 - 124 outcomes across the YEF outcomes framework.
- **Five studies** contributed professional outcome data, providing **22 professional outcomes** for meta-analysis. Four studies were conducted in the UK and one in the USA.
- **Fourteen studies** providing implementation insights. Findings are organised into two overarching domains: (a) implementation processes and delivery capacity, and (b) delivery characteristics.

The remainder of this report is structured as follows: First, the **Description of the Approach** outlines the key components of TI Training and Service Redesign and its intended implementation. Second, **How Effective is the Approach ?** presents findings from our meta-analysis on violence reduction and broader social outcomes. Third, **What Factors Affect Implementation?** explores key factors which influence the implementation of TI Training and Service Redesign approaches. Fourth, **How Much Does It Cost?** reviews available cost data. Finally, the **Conclusion and Takeaway Messages** summarise key findings and

recommendations, followed by **Appendices** detailing the systematic review methodology and characteristics of included research.

Description of the Approaches

Trauma-Informed (TI) Training and Service Redesign are approaches designed to embed an understanding of trauma into the way services are organised, delivered, and experienced. TI Training seeks to improve professionals' knowledge, confidence, and skills in recognising and responding to trauma, while Service Redesign focuses on organisational and system-level changes that support trauma-informed ways of working. Together, these approaches aim to reduce re-traumatisation, strengthen relationships between practitioners and service users, and create environments that better meet the needs of children and young people affected by trauma.

In the following section, details are provided on the evaluations which inform this report noting their key components, any equipment, materials, supplies, or training required, the duration and intensity of interventions, who delivered the interventions, and where and how the interventions were delivered.

Features of the approach

TI practice involves changes to working practices with children and young people who have experienced trauma to actively prevent re-traumatisation. This can be achieved through direct work and through an organisation attempting to address the symptoms and/or effects of trauma in their policies and practices.

TI training is one element in the provision of TI practice and typically works alongside other components such as reflective practice, access to evidence-informed approaches, and development of organisational policies.

Key components of TI Training and Service Redesign

All approaches included in this report were grounded in a TI, relationship-based approach, but they varied in both the populations they targeted, and their level of intensity. Some consisted of a small number of training sessions, while others combined training with broader programmes of support designed to promote systems change.

School-based approaches were the most common, appearing in six studies.^{4,6,17–20} Four of these studies included whole-school or staff development programmes designed to increase understanding of attachment, trauma, and adverse childhood experiences (ACEs), and to strengthen practice in areas such as emotion coaching, reflective practice, behaviour support, and school culture.^{4,6,17,20} Two additional studies focused more narrowly on TI training for teachers, although these interventions did not include wider systems change.^{18,19}

Three studies were linked to the Trauma Recovery Model (TRM), a staged, needs-based approach designed to help professionals understand behaviour in relation to trauma, and highlight the importance of trusted adult relationships in recovery.^{14,21,22}

Two interventions targeted specific professional groups. The Hampshire and Isle of Wight Violence Reduction Unit (VRU) TI Policing Programme²³ aimed to improve police knowledge, attitudes, and practice, while the Fostering Connections programme²⁴ for foster carers and social workers supported TI provision through training and reflective practice.

Three studies described multi-agency services that combined direct work with children, young people, and families with training and consultation for professionals.^{25–27} These services aimed to provide integrated, relationship-based support for children with complex trauma-related difficulties, many of whom were at risk of entering care or the youth justice system. They also sought to embed TI practice more widely across local services and systems.

Finally, one study²⁸ reported a trauma-awareness training course for public sector professionals that focused on understanding trauma and developing trusting relationships in practice.

Different approaches were utilised to bring about the desired outcomes. These included:

- **Face-to-face training.**^{4,6,14,17–28} Most studies described in-person sessions to help professionals work with children, young people and families in TI ways, including understanding trauma and its effects on brain development and behaviour.

- **E-learning and webinars.**^{4,6,17,24,26} Five interventions also used online learning for professionals or for children and young people, often focused on emotions, mental health, and trauma.
- **Leadership and organisational development.**^{4,6,22–24,26} Work with senior leaders included workshops, steering groups, and targeted training to support policy development, organisational culture change, and longer-term implementation. Some programmes also created opportunities for cross-organisation learning and networking.
- **Implementation support.**^{6,14,24,26} Ongoing support was available in four studies through phone calls, coaching, consultancy, and internal champions. In some studies, additional training enabled staff or trauma leads to support colleagues, help embed changes in policy and practice, or act as specialist points of contact within schools or services.
- **Reflective and clinical supervision.**^{4,6,21,22} Four studies highlighted supervision or structured reflection as part of implementation, helping practitioners think through behaviour, needs, and the application of TI approaches in practice.
- **Peer learning and Communities of Practice.**^{6,24,26} Three programmes created spaces for sharing experiences, challenges, and learning across teams, organisations, local areas, or nationally.
- **Multiagency case formulation.**^{14,21,22} Three programmes included support from a clinical or educational psychologist to ensure interventions were based on individual need and that they considered trauma history.

Regarding the training itself, there was considerable overlap in the content of sessions. All interventions included TI practice training, typically covering theoretical and practical information. Other topics included:

- **Adverse childhood experiences (ACEs).**^{4,6,18–20,23,28} Seven programmes explicitly addressed ACEs to support the understanding of children's experiences and needs.
- **Emotions, behaviour, and de-escalation.**^{4,6,14,17,19,20,22–24,28} Content in 10 studies explored emotional development, challenging behaviour, and practical strategies such as de-escalation or emotion coaching.

- **Relationships and communication.**^{4,6,14,24,28} Building trusting relationships and improving communication were also part of some programmes.
- **Attachment and mental health.**^{4,6,17,20,22,28} Seven studies also included attachment theory and training on children and young people's mental health.
- **Broader inclusion and practitioner support.**^{6,19,26} Additional topics included racial trauma and discrimination, celebrating diversity, safety planning for practitioners, and support for excluded or underserved groups.

Equipment, materials, or supplies

Across the studies included in this report, TI Training and Service Redesign approaches drew on a diverse range of resources to support delivery and implementation, including training materials, online learning resources, and practical implementation tools. However, reporting on these resources was often limited and inconsistent, with varying levels of detail provided across studies. Although studies did not always describe the equipment and materials used in detail, training materials and session plans appeared to be common components of intervention delivery. Stepanous et al.⁴ for example, referred to session plans, slides, handouts, and delivery notes.

Some studies also described materials used to support in-person delivery. Two studies^{24,26} referred to games, group activities, and reflective exercises. While Richmond et al.²⁸ described sessions delivered using PowerPoint, videos, and whiteboards, supported by explanations, drawings, and case examples. Whitaker et al.¹⁹ also mentioned the use of stories, analogies, images, activities, and demonstrations.

Digital resources were also important in several interventions. Five interventions included e-learning materials or webinars.^{4,6,17,24,26} In Herrera et al.,⁶ webinars were accompanied by discussion guides, e-books, and 'Helping Teenagers Talk About Their Lives' cards. Stepanous et al.⁴ also reported additional resources such as journals, workbooks, and an online learning platform containing information and support for children, young people, and families. Jacob et al.²⁶ reported that NHS Futures hosted shared resources to support TI practice, including example

policies, descriptions of TI environments, mini CPD sessions, and key presentations. In addition, a bespoke and accessible app was developed to support children and young people to share their views, wishes, and experiences.

Other interventions used practical tools to support implementation. Sparling et al.²⁰ described a toolkit of practical ideas, alongside an audit to help headteachers review existing support systems and identify priorities for development. Similarly, Herrera et al.⁶ reported the use of a school wellbeing audit, staff wellbeing questionnaire, and implementation checklist. McCoy et al.²³ described TI briefings for neighbourhood teams and crib sheets to support TI language in Public Protection Notices.

Who delivers TI Training and Service Redesign

Across the studies included in this report, TI Training and Service Redesign approaches were delivered by a diverse range of professionals and practitioners. Delivery commonly drew on expertise from training, research, health, social care, education, and justice sectors, with some approaches involving multidisciplinary and multi-agency teams to support implementation and service change.

Where stated, a range of roles were involved in delivering approaches, including experienced professional trainers^{6,17,19,24} and researchers or intervention developers.^{18,29}

Other interventions were delivered, at least in part, by consultant social workers, clinical psychologists, or educational psychologists.^{4,14,20–22} In two studies,^{4,14} training was delivered by professionals from a range of disciplines, including social workers, nurses, youth workers, and clinical psychologists.

In two studies^{21,22} delivery was led by professionals from specialist youth justice and mental health services, while in McCoy et al.,²³ TI Practitioners (TIPs) delivered the intervention within the police force. They were recruited and trained by a consultancy service specialising in work with individuals and communities affected by trauma and ACEs.

Three further studies^{25–27} involved direct support to children, young people, families, and other professionals. Central to these studies was multi-agency

collaboration through teams that might include social workers, youth workers, managers, psychiatrists, psychologists, family therapists, and family support staff.

How was the intervention delivered

Across the studies included in this report, TI Training and Service Redesign approaches were delivered using a variety of formats and modes, reflecting the multicomponent nature of many interventions. Delivery commonly combined online and in-person approaches and included both individual and group-based activities, tailored to the objectives of the approach and target population.

In some studies, parts of the approaches were conducted online, either individually^{23,24,26} or in groups.^{4,6,24} This occurred for both training and direct work with children, young people, and families.

Other components were in person, both individually^{14,22,23,25,26} and in groups.^{4,14,17–20,22–26,28} As with the online elements, this included both training and direct work.

In Elvin et al.²⁷ interventions were tailored to need, with delivery occurring both one-to-one and in groups, either in person or virtually via video call, phone call, or email. In Baan et al.²⁴ support was also available to social workers by phone call.²⁴

Where TI Training and Service Redesign is delivered

Across the studies included in this report, TI Training and Service Redesign approaches were delivered in a range of educational, community, and service settings.

Where the intervention setting was reported, five took place in schools.^{4,6,17,18,20} Herrera et al.⁶ described an online intervention delivered remotely via Zoom for staff, while Carter¹⁸ specified that the setting was an alternative school site that supports children with behavioural difficulties and/or special educational needs and disabilities.

The training described in Whitaker¹⁹ appeared to be delivered in the community. In McCoy et al.,²³ training was delivered in both community settings and police stations.

Several interventions were delivered within local authority settings^{14,24,25} or within youth justice services.^{21,22} In Elvin et al.,²⁷ delivery varied according to individual need and could take place at home, in school, or in the community, with virtual sessions available on request. Youth workers were also contactable by text or phone outside planned sessions.

Training for the providers of TI Training and Service Redesign

Across the studies included in this report, information on training for intervention providers was reported inconsistently; however, where described, providers often received specialist training, supervision, and ongoing support. In this report, many approaches were training-based or involved substantial training, but not all studies stated whether intervention providers themselves received training. Two^{6,19} studies noted that trainers were highly experienced and received extensive training, including observation and detailed feedback, while another¹⁴ reported that delivery was led by specialist trainers.

In McCoy et al.,²³ trauma-informed practitioners received training in stalking, domestic abuse, and from the Multiagency Safeguarding Hubs (MASH), alongside monthly peer supervision, mentoring, and observation during twice-yearly site visits. Additional support came from a senior inspector, a multi-agency steering group, and quarterly clinical supervision. Stepanous et al.⁴ also reported supervision for trainers, as well as feedback forms and review of recorded sessions to support fidelity. Trainers were given a digital walkthrough of the curriculum and briefing sessions before delivery. Baan et al.²⁴ noted that trainers completed cultural awareness training before the intervention began.

Elvin et al.²⁷ did not report training for the core team. However, the report did describe training delivered by the team to other professionals, covering topics including county lines, non-violent resistance, and working with complexity.

Duration and intensity of TI Training and Service Redesign

Across the studies included in this report, the duration and intensity of TI Training and Service Redesign approaches varied considerably, ranging from brief training to longer-term approaches with ongoing support and implementation activities.

Available evidence suggests that core training for professionals lasted less than a week. In Herrera et al.,⁶ this training was distributed across two to three terms to maintain momentum.

Interventions varied in both the amount and duration of additional support provided. Where reported, shorter interventions ranged from four weeks¹⁸ to 12 weeks,¹⁹ while in Coulton et al.¹⁴ they typically lasted between one and nine months.

Longer interventions lasted from one year²⁴ to 15 months^{4,6}. Facer-Irwin et al.²² reported a two-year pilot, which was then rolled out across all teams.

How Effective is the Approach?

This section examines the effectiveness of TI Training and Service Redesign approaches in relation to (i) child-level violence and other related outcomes, and (ii) professional outcomes, including practitioners' trauma-informed attitudes, knowledge and practice, relationships and trust, emotional regulation, empathy, and professional wellbeing. Findings are synthesised through a systematic review and meta-analyses, to provide a robust and objective summary of existing evidence by, incorporating advanced statistical techniques, and including robust variance estimators ³⁰, for improved accuracy.

Quantitative data from **5 effectiveness studies** met the inclusion criteria detailed in [Appendix 1](#).

Child-related outcomes were reported in four studies contributing **124 outcomes** related to the TI Training and Service Redesign. One multi-arm trial contributed data from two study arms,²⁴ resulting in five study arms contributing to the analysis. Consequently, although only four studies were included, five study arms contributed data to the analysis.

The professional outcomes were reported in five studies contributing **22 outcomes** related to the impact of TI Training and Service Redesign.

Across the five included studies, data were available for a total of **12, 739 children and young people and 2,005 professionals**. Of the 5 studies, one was an individual Randomised Controlled Trial (RCT), while the remaining four of the five studies were cluster randomised controlled trials. One cluster randomised controlled trial was a multi-arm trial,²⁴ which contributed two intervention arms to the child analysis, while contributing one arm to the professional analysis.

The five effectiveness studies varied in their methodological design and reporting characteristics (see [Appendix 3](#) for individual study details).

All five studies used a prospective design and assigned participants at the start of the study (100%). One study allocated at the level of individual participants (20%), whilst all other studies were cluster-RCTs (n = 5, 80%). Of the cluster-RCTs, two

were randomised at the school level,^{4,6} one was randomised at the classroom level,¹⁹ and one was randomised at the young person's social worker level.²⁴

The effectiveness studies spanned the past two decades, with the earliest conducted by Whitaker et al. in 2019,¹⁹ and the other four studies published in 2026.

The studies were conducted in three countries including:

- England: (n = 3, 66%)
- Wales: (n = 1, 17%)
- USA: (n = 1, 17%)

Fuller descriptions of the included studies are available in [Appendix 3](#). Studies were assessed for methodological quality using the Youth Endowment Fund Evidence Quality Assessment (YEF-EQA) which is critical appraisal tool and were rated as follows:

- High: (n = 4, 80%)
- Moderate: (n = 1, 20%)

All studies reported their funding sources. Across the five studies, three (60%) received funding from Foundations or Charities, one study (20%) received funding from Foundations or Charities and Government, while one study (20%) received funding from a Research Grant. Two of the included studies (40%) explicitly declared no conflict of interest and two studies (40%) did not explicitly mention whether they had any conflict of interests to disclose. Whitaker et al.¹⁹ did express a possible conflict of interest (n = 1, 20%), disclosing that the lead author received an honorarium for serving as a member of an advisory board for TI Policies and Practices, from the Robert Wood Johnson Foundation. However, information about the approach provided in the supplementary material for the study confirms that the study authors were not involved in the development or delivery of the approach and were independent evaluators.

Due to the multi-component nature of the approaches in the included studies, with different components running for varying amounts of time, treatment intensity was classified by the research team into distinct tiers. Very intensive

approaches involved substantial time commitments (often ≥ 6 months, multiple weekly sessions, and multi-component delivery), while moderately intensive approaches typically consisted of weekly or bi-weekly sessions over 8–16 weeks. Low-intensity interventions were brief, usually involving 10 or fewer sessions. Four of the included studies (80%) were classified as very intensive approaches and one study (20%) as moderately intensive. Approaches also differed in duration, one study (20%) lasted 1–3 months; one study (20%) lasted 6–12 months; and a further two studies (40%) lasted 1–2 years. One study (20%) did not explicitly state how long the intervention lasted.

Approaches were delivered in various settings. Two studies (40%) were conducted using a combination of in-person delivery within a school setting and digital/computerised methods. One study (20%) delivered approaches in-person within community facilities, alongside digital/computerised methods. Two studies (40%) did not state where the approaches were delivered. Most approaches were delivered by mental health or therapeutic professionals, including clinical psychologists specialising in trauma and accredited TI programme trainers ($n = 4$, 80%). One other approach (20%) was delivered by experienced facilitators and trainers from non-profit and charity organisations.

Demographic representation of study participants was generally mixed across the included studies. Most studies had mixed-sex samples, with these being a relatively even split of males and females ($n = 4$, 80%). One study (20%) did not provide information on the gender distribution of the children and young people reached by the approaches. Across studies that reported gender, females constituted the majority of recipients.

The included studies represented a range of developmental stages. One study focused on professionals working with young children, between the age of 3–4 years (20%); two studies targeted early adolescents, aged 12–14 years (40%); and two studies included a mixture of ages ranging from 10 to 21 years of age (40%).

The ethnic and racial composition of children and young people varied across the included studies. Of the five unique studies, four provided data on race or ethnicity (80%), whilst one study did not provide this information for the children and young people that professionals engaged with (20%). Of those studies that

did provide children and young people's race or ethnicity information, one study reported a predominately white sample, inclusive of over 90% white participants (20%). Two studies included some diversity, with samples that were majority white, but still included representation of children and young people from Black and Global Majority backgrounds, ranging from approximately 20–30% of the sample (40%). One study reported a diverse/balanced sample where around half of participants were from a Black and Global Majority background (20%).

Reporting of socio-economic status varied across the individual studies. One approach targeted professionals who taught children and young people exclusively from low-income families (20%). Two studies included children and young people from mixed income families, denoted by eligibility for free school meals (40%). The remaining two studies did not provide explicit information on the socio-economic status of the included children and young people (40%).

Measured outcomes

Across the five effectiveness studies, a total of 146 outcomes were identified and extracted. Of these, four studies contributed 124 child outcomes, spanning 13 outcome categories within the YEF Outcomes Framework, while 5 studies contributed 22 professional outcomes measuring trauma- informed attitudes, relationships, trust, emotional skills, staff wellbeing, and broader behavioural and health outcomes. Behavioural outcomes included perspective-taking, while health outcome measures included the extent to which poor health interfered with usual activities. Professional outcomes also included compassion satisfaction, personal distress, and trauma-informed attitudes and competencies (measured using the ARTIC scale).

Focusing on child outcomes, the 124 outcomes identified across four studies spanned **13 outcome categories** within the YEF Outcomes Framework:^b Outcomes presented in Table 1 could be assigned to more than one category, therefore, the

^b The [YEF Outcomes Framework](#) identifies specific outcomes linked to reducing the risk of children and young people becoming involved in crime and violence, providing a structured approach for measuring the impact of interventions.

categories presented are not mutually exclusive and do not sum to the total number of outcomes identified.

Table 1 Distribution of Child-Related Outcomes Across Outcome Categories within the YEF Outcomes Framework

Outcome	Number of outcomes (k)	Number of studies (n)
General mental health	25	5
Behavioural difficulties	20	5
Building and maintaining relationships	20	5
Regulating and managing emotions	20	5
Helping others	13	5
School engagement	13	3
Crime and offending	5	1
Family relationships and support	2	1
Stable provision of care services	2	1
Bullying	1	1
Family conflict	1	1
Goals for the future	1	1
Victim of crime	1	1

To inform our violence estimate, outcomes were required to measure violent crime or violent offending, or overt or relational aggression directed at another person. Measures of bullying were included where studies defined bullying as repeated physical violence or repeated verbal harassment.

Across the 4 studies that met these criteria, we identified 22 violence outcomes. Of these, 20 were related to behavioural difficulties, 1 related to bullying, and 1 related to crime and offending.

There were insufficient data to conduct a separate meta-analysis of crime and offending outcomes ($k=5$, $n=1$).

Outcomes were derived in several ways, including child self-report survey measures ($k=100$; 68%), followed by professional assessment/observation ($k=37$; 25%)— including teachers ($k=20$), social workers ($k=1$), and foster carers ($k=16$)— and administrative records ($k=9$; 6%).

For the analyses presented below, negative SMD values indicate effects in a beneficial direction.

We present summary results from a multivariate meta-analysis on the impact of TI Training and Service Redesign on violence in (Table 1).

Table 2: Summary of findings on violence

Outcome	SMD	CI (95%)	P	% reduction	Impact rating	Number of studies (study arms)	Evidence rating
Violence only	-0.04	-0.09 to 0.02	0.28	6%	Small	4 (5)	3

Meta-analysis of violence outcomes in TI Training and Service Redesign

TI Training and Service Redesign is associated with a small impact on violence, corresponding with a 6% reduction in violence, based on 22 measured outcomes across 4 studies.

The primary focus in the initial analysis is the reduction and prevention of violence, as defined by YEF. Violence is a broad construct that incorporates incidents/behaviours as well as convictable offences. Violence may be of a physical, verbal, psychological, or sexual nature.³¹

The team identified 22 outcomes measuring **violence** specifically across four Type A studies, providing an overall security rating of **Level 3**.

Most violence outcomes assessed behavioural difficulties, while several focused on bullying; crime and offending outcomes were assessed using measures of delinquency.

A total of $k = 22$ outcomes were included in the analysis, derived from five study arms across four studies. The estimated average outcome based on the random-effects model was $\hat{\mu} = -0.04$, (95% CI: -0.09, 0.02); $p=0.28$.

This estimate was not statistically significantly different from zero $t = -1.34$, $p = 0.28$.

Table 3: Robust Variance Estimation (RVE) output for meta-analysis on violence outcomes

	Estimate	SE	t-stat	d.f (Satt)	p-val (Satt)	Sig	YEF impact rating	YEF evidence security rating
Intercept	-0.04	0.03	-1.34	2.72	0.28	N.S.	Small	3

In practical terms, this indicates that the approach may be associated with a small reduction in violence-related outcomes across four studies. Based on YEF impact categorisation, the effect size ($g = -0.04$) corresponds to a “small impact” rating. However, as the p-value is above .05, the reader cannot rule out the possibility that the true average effect is actually zero. The prediction interval is relatively wide (-0.11 to 0.04), and indicates that the true effect in a new, similar study could plausibly range from a small reduction to a small increase in violence-related outcomes.

According to the Q-test, there was no evidence of heterogeneity; $I^2 = 0\%$, $Q(df = 21) = 7.43$, $p = .997$. This suggests that the analysis did not detect statistically significant variability in effect sizes.

The SMD of -0.04 corresponds to a relative risk reduction of 6% in the risk of re-committing violence, with an absolute risk reduction of 1%. Based on this estimate, violence outcomes were observed in 15% of children and young people in services implementing TI Training and Service Redesign approaches, compared to 16% in comparison services (see Figure 1).

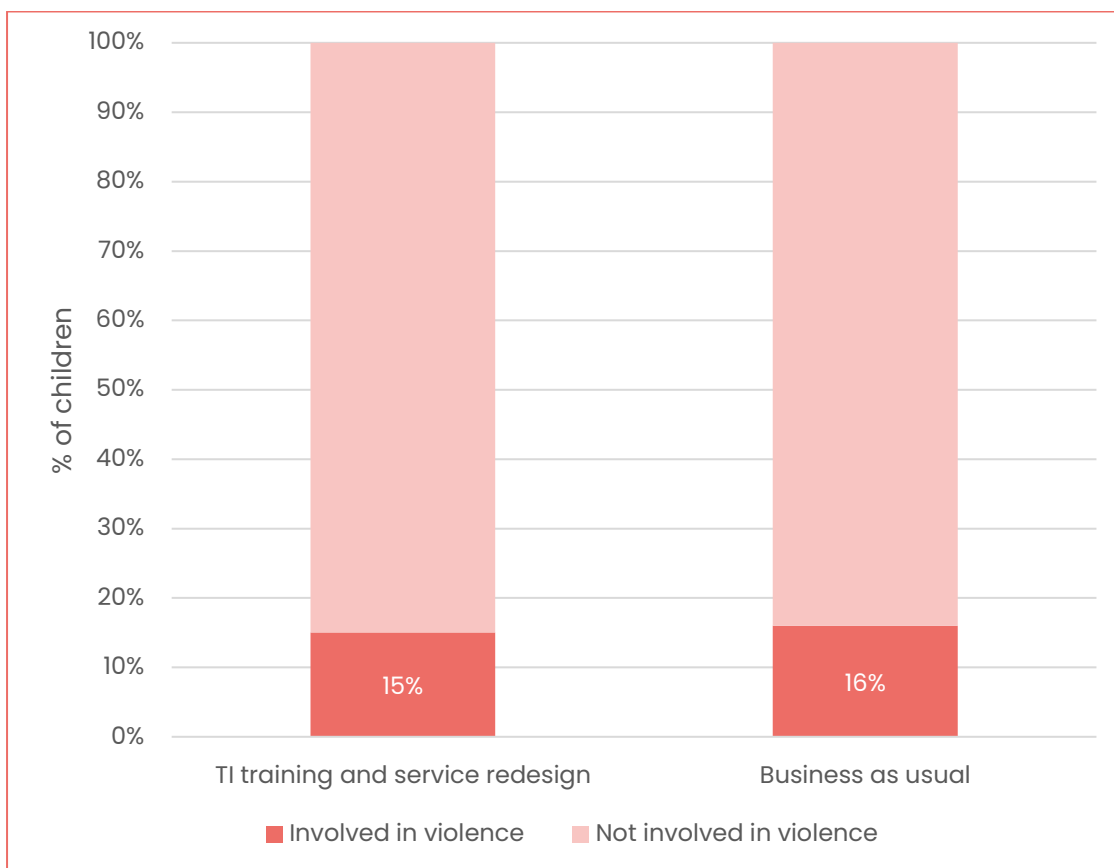


Figure 1: Absolute risk reduction in violence associated with TI Training and Service Redesign approaches compared to business as usual

Meta-analysis of all related outcomes in TI Training and Service Redesign

Including the violence, crime, and offending outcomes described above, the team extracted a total of 124 measured child outcomes from 4 Type A effectiveness

studies that align with the YEF outcomes framework. This provides an overall security rating of **Level 3**.

A total of $k = 124$ outcomes were included in the analysis, derived from five study arms across four studies. The estimated average outcome based on the random-effects model was $\hat{\mu} = -0.01$, (95% CI: -0.03, 0.01).

This estimate was not significantly different from zero, $t = -0.81$, $p = .477$.

Table 4: RVE output for meta-analysis of all child-related outcomes

	Estimate	SE	t-stat	d.f (Satt)	p-val (Satt)	Sig	YEF impact rating	YEF evidence security rating
Intercept	-0.01	0.01	-0.81	3.06	0.477	N.S.	No effect	3

In practical terms, this indicates that there was no evidence of effect of TI Training and Service Redesign approaches across the full set of child outcomes examined. The pooled effect size was close to zero, suggesting little difference in outcomes in those experiencing TI Training and Service Redesign approaches, and those in the comparison conditions. The prediction interval (-0.05 to 0.03) indicates that the true effect in a new, similar study is likely to remain close to zero, but could plausibly range from a small reduction to a small increase in desirable outcomes.

According to the Q-test, there was no evidence of heterogeneity; $I^2 = 0\%$, $Q(df = 123) = 68.50$, $p = 1$. This suggests that the observed effects were highly consistent.

Meta-analysis of professional outcomes in TI Training and Service Redesign

The team identified 22 outcomes measuring **professional outcomes** specifically across five studies: 4 Type A, and 1 Type C, giving an overall security rating of **Level 3**. Most professional outcomes measured trauma-informed attitudes, relationships, trust, emotional skills, staff wellbeing, and broader behavioural and health outcomes.

A total of $k = 22$ outcomes were included in the analysis, derived from five studies across five study arms. The estimated average outcome based on the multilevel random-effects model was $\hat{\mu} = -0.06$, (95% CI: -0.15 to 0.03). This estimate was not statistically significantly different from zero in the initial model $t = -1.3$, $p = 0.341$.

Table 5: RVE Output for meta-analysis on professional outcomes

	Estimate	SE	t-stat	d.f (Satt)	p-val (Satt)	Sig	YEF impact rating	YEF evidence security rating
Intercept	-0.06	0.05	-1.3	1.72	0.341	N.S.	Small	3

In practical terms, this indicates that there was evidence of a small beneficial effect of TI Training and Service Redesign approaches on professional outcomes across five studies. Based on YEF impact categorisation, the effect size ($g = -0.06$) corresponds to a “small impact” rating. However, as the p-value is above .05, the reader cannot rule out the possibility that the true average effect is zero. The prediction interval is relatively wide (-0.20 , 0.08), and indicates that the true effect in a new, similar study could plausibly range from a small reduction to a small increase in violence-related outcomes. According to the Q-test, low heterogeneity was present; $I^2 = 20.9\%$, $Q(df = 21) = 26.55$, $p = .186$. This level of variability suggests the observed effects were relatively consistent, although some modest variability remains.^c

Publication bias

The meta-analyses included only a small number of studies: four studies for violence and all child outcomes, and five studies for professional outcomes. This

^c Studies included different groups of professionals (e.g., teachers, social workers, youth workers), which may contribute to some variability in effects.

makes any formal assessment of publication bias infeasible. As the Cochrane Handbook notes, funnel plots and related methods are generally uninformative when fewer than 10 studies are available, as tests with fewer studies lack adequate power to distinguish real bias from chance.³²

Our searches and inclusion criteria were intentionally broad and objective, encompassing both academic and grey literature to reduce the risk of publication bias. Nonetheless, the possibility remains that other evaluations with null or negative findings were either not reported or not accessible, consistent with the “file drawer problem.”

Sensitivity analyses

Sensitivity analyses were conducted for all child outcomes, and for professional outcomes.

All child outcomes

An examination of the studentized residuals revealed that residuals were close to zero, indicating no evidence of substantial outliers. Using Cook’s distance (see Figure 2) with a threshold of 0.032, 4 outcomes were identified as potentially influential.

A leave-one-out analysis was conducted to examine the extent to which omitting individual outcomes altered the overall effect estimate. The largest change in the overall effect estimate was 0.004, indicating a very small (negligible) change. The analysis also examined the influence of individual outcomes on heterogeneity, the original model indicated no between-study heterogeneity ($I^2 = 0.0\%$), and this remained unchanged across all leave-one-out models (see Figure 3).

In practical terms, these changes were very small, indicating that no single outcome or study materially altered the magnitude, direction, or statistical significance of the overall effect in either meta-analysis.

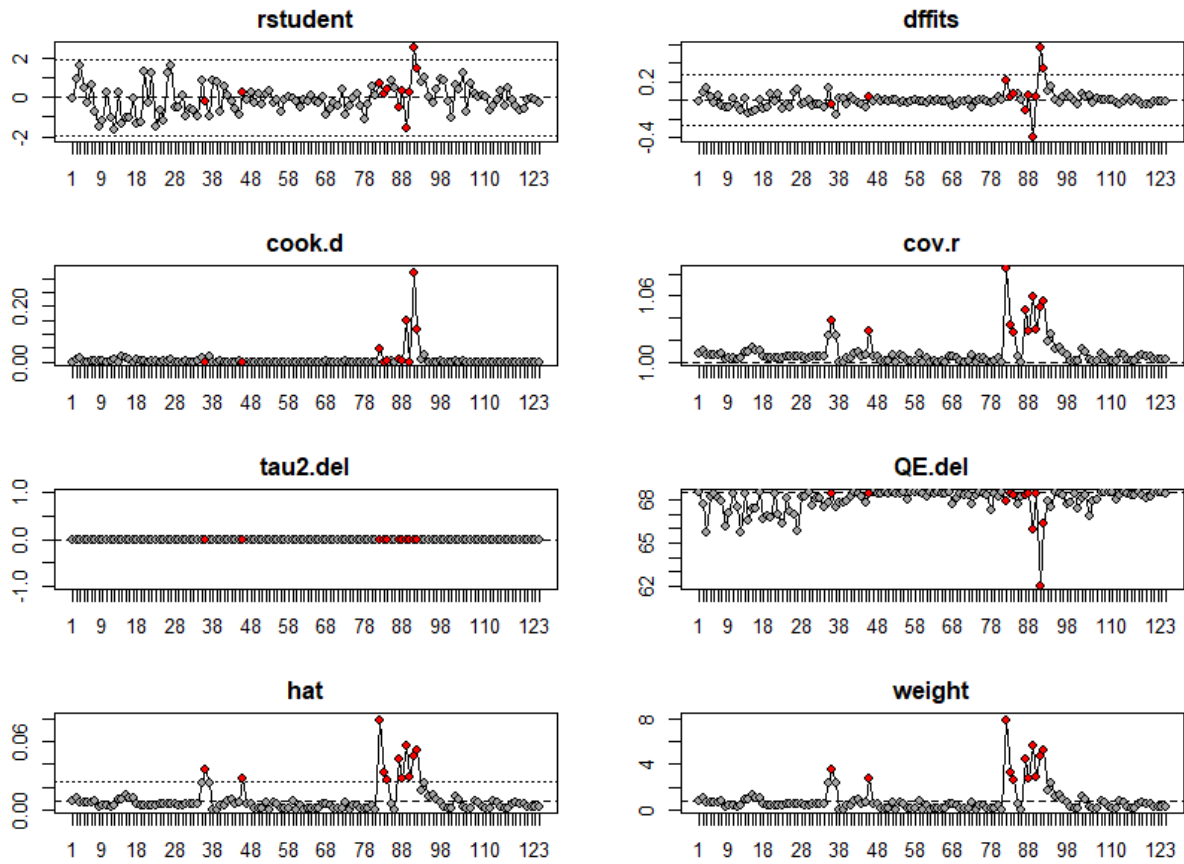


Figure 2: Influence diagnostics for individual child outcomes

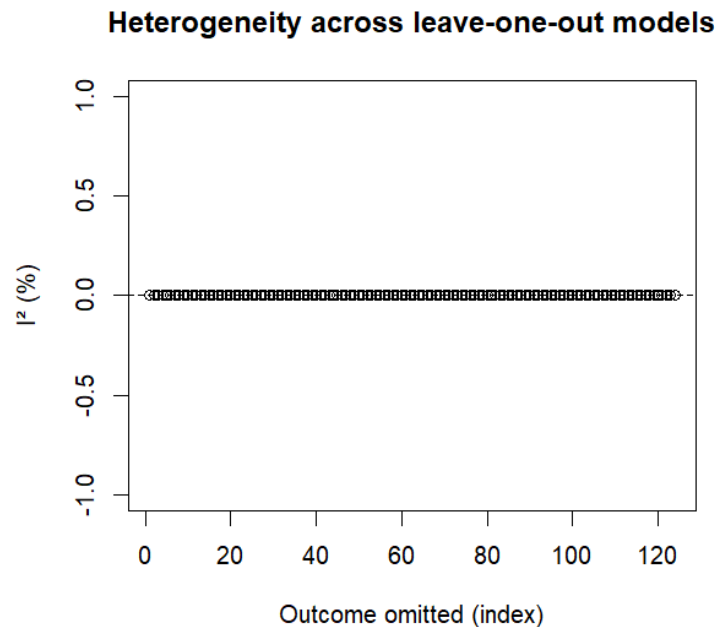


Figure 3: Heterogeneity across leave-one-out sensitivity analysis for the child outcomes meta-analysis

Overall, the main conclusion appears reasonably robust: the pooled effect remains close to zero across all sensitivity analyses.

Professional outcomes

An examination of the studentized residuals revealed no evidence of substantial outliers. Using Cook's distance with a threshold of 0.182, no outcomes exceeded this value (see Figure 4).

A leave-one-out analysis was conducted to examine the extent to which omitting individual outcomes altered the overall effect estimate. The largest change in the overall effect estimate was 0.010. The analysis also examined the influence of individual outcomes on heterogeneity. The original model indicated low between-study heterogeneity ($I^2 = 20.9\%$). Across the leave-one-out models, the I^2 values ranged from 0.00% to 0.03% (mean = 0.01%, see Figure 5).

In practical terms, these changes were very small, indicating that no single outcome or study materially altered the magnitude, direction, or statistical significance of the overall effect in either meta-analysis.

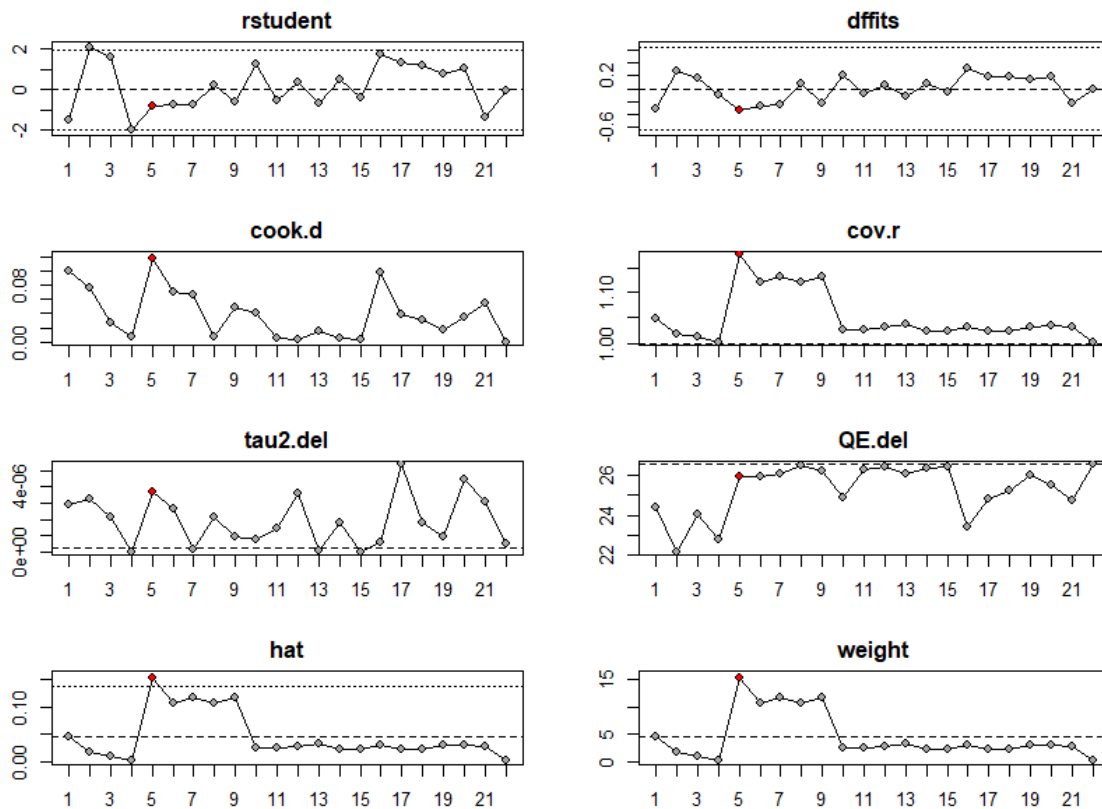


Figure 4: Influence diagnostics for individual professional outcomes

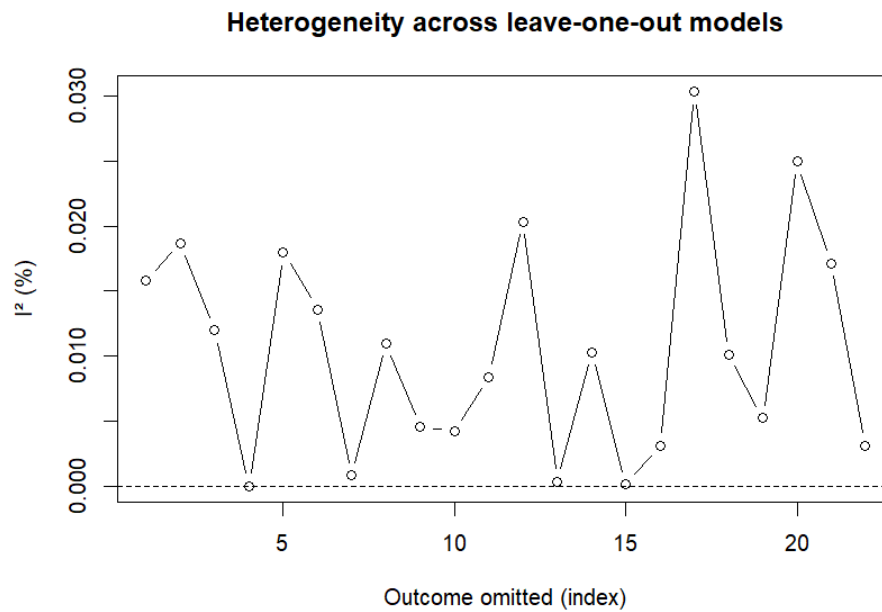


Figure 5: Heterogeneity across leave-one-out sensitivity analysis for professionals

Overall, the main conclusions appear reasonably robust.

How Secure is the Evidence?

Violence outcomes

Our confidence in the findings on the prevention and reduction of violence is **Moderate**. The evidence for violence achieved an initial security rating of **Level 3**. This is based on four studies assessing the impact of TI Training and Service Redesign approaches. All studies were high quality (Type A).

There was no evidence of heterogeneity between outcomes, meaning that the estimated effects were broadly consistent.

All child outcomes

Our confidence in the finding relating to all child outcomes is **Moderate**. The full effectiveness analysis achieved an overall security rating of **Level 3**. The combined evidence base consists of 4 studies assessing the impact of TI Training and Service Redesign approaches on child outcomes. All studies were high quality (Type A).

There was no evidence of heterogeneity between outcomes ($I^2 = 0.0\%$), meaning that the estimated effects were broadly consistent, and the **Level 3** evidence security rating was maintained.

The results were generally robust across sensitivity analyses and after applying robust variance estimation to account for dependent effect sizes. These findings do not provide evidence of a statistically significant beneficial effect of TI training and service redesign on children's overall outcomes.

Professional outcomes

Our confidence in the findings on professional outcomes is **Moderate**. The meta-analysis included 22 professional outcomes drawn from five studies

The studies included:

- Four studies rated as high quality (Type A); one study rated as moderate quality (Type C).

Heterogeneity was low ($I^2 = 20.9\%$), meaning the **Level 3** evidence security rating was maintained.

Who Does It Work For?

This narrative summary of equity-related outcomes supplements the meta-analysis by providing additional insights into how TI Training and Service Redesign approaches may affect different demographic groups.

Two studies provided detail in relation to personal characteristics that help to explain for whom TI Training and Service Redesign programmes work.^{4,6} The studies covered gender, ethnicity, socio-economic status and Special Educational Needs and/or Disabilities (SEND). Both studies were conducted in the UK and were assessed as high quality according to the YEF-EQA tool. However, this evidence base is limited, and several categories were informed by only one study. Consequently, conclusions regarding which groups benefit most from these approaches should be considered tentative and interpreted with caution.

Studies where personal characteristics of the sample were described (e.g. gender) but not specifically related to outcomes of interest or do not contribute to the understanding of who TI Training and Service Redesign programmes work best for, have not been included in this section. No studies explored age, education, care-experience, neurodiversity, intersectionality, or place of residence.

Gender

One study examined whether gender moderated the effects of a whole-school TI approach.⁶ Year 8 pupils in schools implementing Trauma Informed Schools UK were compared with those receiving a business-as-usual provision. Outcomes were measured using the Strengths and Difficulties Questionnaire (SDQ). No significant intervention effects on externalising behaviour were identified when analysed separately for males and females, and analyses across individual SDQ subscales likewise found no significant gender differences.

A quasi-experimental analysis of pupils receiving targeted support, matched to controls using propensity score matching, similarly found no significant gender

differences in externalising behaviour. Additional subgroup analyses across individual SDQ subscales were provided by the authors. These analyses indicated mixed and domain-specific effects. Among pupils receiving targeted support, females in the intervention group had significantly higher conduct and emotional problem scores than controls, suggesting worse outcomes. Males showed significantly higher hyperactivity scores alongside higher prosocial behaviour scores. These findings indicate possible gender-specific patterns across outcome domains; however, they are subject to methodological limitations including small sample sizes and should be interpreted cautiously.

Ethnicity

Two studies examined whether ethnicity moderated the effectiveness of TI approaches.^{4,6} Herrera et al.⁶ evaluated Trauma Informed Schools UK using a cluster RCT across schools, alongside a quasi-experimental analysis of a subgroup of pupils receiving targeted support. Stepanous et al.⁴ evaluated the More Good Days at School programme using a cluster RCT across secondary schools. Both studies used the SDQ and conducted subgroup analyses. Overall, findings provide limited and inconsistent evidence of differential effects.

In Herrera et al.,⁶ no significant ethnic group differences were observed in externalising behaviour in the main trial analyses. Additional subgroup analyses across individual SDQ subscales were provided by the authors. The results suggested some positive effects, including higher prosocial behaviour among Black Caribbean and Black African pupils and lower peer problems among white pupils. However, among pupils receiving targeted support, several analyses indicated higher scores for white pupils (conduct, hyperactivity, emotional problems) and mixed-ethnicity pupils (peer problems). These findings were constrained by methodological limitations and small subgroup sizes, with some ethnic groups excluded due to insufficient sample sizes.

Stepanous et al.⁴ reported small subgroup differences. Slight increases were observed for Asian and Black pupils on emotional symptoms and for Black pupils on peer problems, alongside a small decrease in emotional symptoms for those pupils classified as 'Other.'. All other effects were negligible and non-significant.

Taken together, the evidence does not demonstrate consistent or robust differences in effectiveness by ethnicity. Observed subgroup effects were small, inconsistent, and frequently limited by methodological constraints, leaving conclusions uncertain.

Socio-economic Status

Two studies investigated whether socio-economic status moderated TI Training and Service Redesign intervention effects, ^{4,6} with mixed findings.

Herrera et al.,⁶ using the Index of Multiple Deprivation (IMD), found no significant differences in externalising behaviour by deprivation level in the main RCT. Additional analyses on the individual SDQ subscales also revealed no significant effects by socio-economic status. However, analyses of pupils receiving targeted support suggested differential effects. Pupils from the least deprived backgrounds in the intervention group showed higher externalising behaviour than controls. Analyses indicated higher hyperactivity and peer problems among the most deprived pupils, and higher emotional difficulties among the least deprived pupils. These findings suggest potential adverse effects across socio-economic groups but are limited by small samples and the non-randomised design.

In contrast, Stepanous et al.⁴ used free school meal eligibility as a proxy for low socio-economic status and found no significant or meaningful subgroup differences across SDQ outcomes.

Taken together, evidence on socio-economic status moderation is limited and inconsistent, with insufficient basis for firm conclusions regarding differential effectiveness.

SEND

One study assessed whether a whole-school TI approach (More Good Days at School) produced differential effects for pupils with SEND.⁴ Subgroup analyses across SDQ subscales found negligible and non-significant effects, indicating no measurable improvements relative to usual practice.

However, the study was not designed to assess effectiveness within SEND populations, and outcomes were not disaggregated by type of need. It therefore

remains unclear whether effects vary across SEND subgroups. Further research is required to determine how TI approaches can be adapted to meet diverse SEND needs.

What Factors Affect Implementation?

Fourteen studies provided evidence related to the implementation of TI Training and Service Redesign.^{4,6,14,17,18,21–29} Using the YEF-EQA tool, three papers were classified as high- quality studies,^{4,14,18} five as moderate- quality studies,^{6,22–24,27} five as low- quality studies,^{17,21,26,28,29} and one as a very low- quality study.²⁵ Thirteen studies took place in the UK,^{4,6,14,17,21–29} and one study took place in the US.¹⁸ Individual study details are available in [Appendix 4](#).

Factors examined in this review are organised into two overarching domains: (a) implementation processes and delivery capacity, and (b) delivery characteristics. All fourteen studies included in this review contributed evidence across each of these domains. The process of identifying themes across studies is described in [Appendix 1](#).

Implementation processes and delivery capacity

Implementation processes and delivery capacity include implementation variables such as fidelity, intervention providers and training, reach and penetration, and adaptations to address equity-related characteristics.

To briefly summarise, key themes from this section highlight that for TI Training and Service Redesign programmes to be most effective, the following should be established during implementation:

- Clear articulation of core programme principles and implementation expectations is essential from the outset, ensuring alignment across fidelity, workforce delivery, organisational embedding, and adaptation processes.
- Fidelity should be conceptualised broadly, combining adherence to core intervention components with the consistent enactment of TI, relational, and developmentally responsive practice across settings and over time.

- Intervention providers must be credible, relational, and appropriately skilled, with multidisciplinary and specialist input (e.g. psychologists, youth workers, lived-experience contributors) enhancing engagement, confidence, and implementation quality.
- Training should function not only as knowledge transfer but as a mechanism for legitimising relational practice, supporting shifts in how behaviour is understood and enabling practitioners to adopt TI approaches within constrained systems.
- Ongoing reflective supervision, consultation, and coaching are critical implementation infrastructure, sustaining fidelity, supporting workforce wellbeing, and enabling translation of training into routine practice.
- Leadership engagement and shared frameworks are key enablers of consistency and system-wide embedding, providing strategic direction, common language, and alignment across teams, organisations, and sectors.
- Reach is typically strongest among high-need and underserved populations, particularly where interventions use flexible, relational, and multi-agency pathways; however, representativeness and equity of access require deliberate attention.
- Penetration into organisational systems is variable and requires active embedding, with strongest implementation observed where TI approaches are integrated into policies, supervision, induction, and cross-agency working, rather than remaining at the level of individual practice.
- Implementation effectiveness is highly contingent on workforce capacity and organisational conditions, with staffing pressures, turnover, competing priorities, and system misalignment posing significant risks to fidelity, reach, and sustainability.
- Adaptation should be anticipated and strategically managed, balancing flexibility with preservation of core components, and extending beyond operational adjustments to include more explicit, equity-informed

adaptations addressing cultural relevance, inclusion, and structural inequalities.

A comprehensive analysis of the findings across each domain is presented in the sections that follow.

Fidelity

Fidelity refers to the degree to which interventions are delivered as intended, encompassing both the quality and consistency of implementation. This includes how closely delivery aligns with the original design, the factors that support or hinder high-fidelity implementation, and the processes used to monitor, assess, and provide feedback on delivery.

Across the 14 included studies (see Appendix 4), fidelity was conceptualised not only as adherence to prescribed intervention components, but also as the consistent enactment of TI, relational, and developmentally responsive principles within practice. Most interventions maintained strong fidelity to their core training and programme designs. However, there was notable variation in how well TI approaches were integrated into organisational systems, how consistently they were sustained over time, and the extent to which implementation was uniform across practitioners and sites.

Five overarching themes were identified across the evidence:

- 1) Strong fidelity to core training and relational principles;
- 2) The importance of reflective supervision, leadership, and shared frameworks in supporting fidelity;
- 3) The balance between fidelity and contextual adaptation;
- 4) Systemic and organisational barriers limiting sustained high-fidelity implementation.
- 5) Monitoring, feedback, and fidelity assessment

The following sections of this report examine each of these themes in detail.

1. Strong fidelity to core training and relational principles

Core trauma-informed principles and programme models were implemented across studies, with training, case formulation, and relational approaches identified as important features supporting implementation.

Strong fidelity to core training and relational principles was evident across studies, particularly in relation to staff training, TI case formulation, and relational approaches to practice. For example, in the Enhanced Case Management (ECM) evaluation, Cordis Bright²¹ examined implementation of a TI youth justice model. This model involved psychologist-led supervision and multidisciplinary formulation meetings which were focused on underlying developmental and mental health needs, with interventions explicitly sequenced according to intervention priorities. The evaluation found that all participating young people received case formulation meetings and at least one review meeting as intended. Formulation reports showed strong alignment with Trauma Recovery Model (TRM) principles, developmental sequencing, and TI intervention planning. Similarly, Bond-Taylor et al.,²⁵ when evaluating the Lincolnshire Children and Young People's (CYP) Complex Needs Service, found high levels of fidelity to a TI, multi-agency model, with strong staff engagement in core components such as formulation clinics and consultation. Practitioners widely perceived that support was aligned with TI practice. Baan et al.²⁴ evaluated the 12-month Fostering Connections programme across eight local authorities and reported that core training sessions were delivered consistently. Facilitators achieved session aims in 99% of activities and fully covered required content in 86% of sessions. Additionally, Herrera et al.⁶ likewise observed strong provider-level fidelity in the delivery of whole-school training, leadership sessions, and diploma courses within the Trauma Informed Schools UK Training and Implementation programme, despite variation in school-level embedding.

Fidelity as embedded trauma-informed values and relational practice was also a consistent theme, with several studies highlighting that fidelity extended beyond procedural adherence to include the consistent application of TI values and relational approaches in day-to-day work. Facer-Irwin²² examined the implementation of the TRM within the Youth Justice Service, where fidelity was reflected in staff adopting a sustained TI "lens" across everyday interactions, assessment, and decision making. This was supported by a broader conceptual shift in which offending was increasingly understood in relation to trauma and adversity, alongside a move away from deficit-focused language towards more relational and needs-based terminology. Furthermore, Jacob et al.,²⁶ when

evaluating the Humber and North Yorkshire Children and Young People's Trauma Informed Care Programme across multiple sites, reported variation in delivery models, with some sites focusing on direct work and others adopting whole-family approaches. Despite these differences, fidelity was maintained through consistent relational principles, including flexibility, emotional safety, collaboration, and TI understanding. Comparable findings were reported in the South East Framework for Integrated Care (Community)(FfIC)Vanguard evaluation²⁷ with implementation of both the Thames Valley Link Programme and Building Belonging Programme showing strong alignment with TI and child-centred principles. This consistency was maintained despite differences in operational models and local delivery arrangements. Taken together, this suggests that fidelity was sustained not only through adherence to specific models, but through the consistent application of shared TI values across different approaches.

Relational consistency also emerged as a key feature of fidelity in interventions delivered directly to children and young people. Coulton et al.¹⁴ evaluated the Relationship Building Together (RBT) model, delivered across multiple youth-facing services. They reported that fidelity depended not only on adherence to structural processes such as screening and tier allocation, but also on the quality of therapeutic alliance, collaboration, and person-centred communication. Quantitative findings demonstrating associations between stronger therapeutic alliance and improved outcomes reinforced this broader conceptualisation of fidelity. This indicates that strong, trusting relationships are a central component of fidelity and are closely linked to improved outcomes for children and young people.

2. Reflective supervision, leadership, and shared frameworks as fidelity mechanisms

Reflective supervision, leadership support, and shared trauma-informed frameworks were frequently identified as key mechanisms for supporting implementation fidelity and maintaining consistency in practice across settings.

Reflective supervision, ongoing consultation, and strong leadership support

were consistently identified as facilitators of high-fidelity implementation across settings. Clinical supervision delivered by psychologists or specialist practitioners was frequently highlighted as an important feature in supporting fidelity across several interventions. Facer-Irwin²² reported that reflective supervision supported practitioners to sustain compassionate and reflexive approaches despite operational pressures and emotionally demanding youth justice work. Staff reported that the TI lens could easily become diluted without ongoing reflective oversight. In the ECM model,²¹ clinical supervision from the All Wales Forensic Adolescent Consultation and Treatment Service (FACTS) psychologists supported TI formulation and improved attention to underlying need. However, access to training was sometimes limited, and early uncertainty existed about the role of external supervision versus managerial oversight. The authors do note that this was largely resolved through clarification of advisory roles during the intervention.

Supervision and reflective structures were reported as features for reinforcing consistency and shared understanding across organisations. The South East FfIC Vanguard programmes²⁷ embedded fidelity through reflective practice events, steering groups, annual reviews, and multidisciplinary learning structures involving NHS, youth justice, education, and voluntary sector partners. McCoy et al.,²³ in their evaluation of the Trauma Informed Policing Programme, similarly reported that structured peer supervision, body-worn video review, and reflective case discussions supported officers to embed TI policing approaches into operational practice. Across school-based interventions, ongoing coaching, reflective journaling, consultation groups, and collaborative learning structures similarly reinforced implementation consistency.^{4,18} Taken together, this indicates that shared reflective structures help support fidelity by aligning understanding and practice across professional groups and organisational boundaries.

Leadership engagement was consistently reported in relation to fidelity.

Implementation was typically described as stronger where senior leaders actively championed TI approaches and integrated them into organisational policies, systems, and culture. This pattern is illustrated in Attachment Aware Schools,¹⁷ a whole-school professional development programme focused on attachment theory and emotion coaching. Senior leadership participation and resource

allocation were repeatedly identified as essential for maintaining implementation momentum.¹⁷ Similarly, Herrera et al.⁶ reported that schools with strong leadership engagement were more likely to integrate the programme fully, including removing punitive practices (e.g. isolation booths) and adopting restorative approaches. In contrast, schools with weaker leadership buy-in appeared to implement the programme more superficially, limiting fidelity to its intended whole-school transformation model. Likewise, in the Trauma Informed Policing Programme,²³ strategic support from senior police leadership and the Violence Reduction Unit legitimised the intervention and encouraged engagement from frontline officers.

Shared conceptual frameworks also supported fidelity by creating common language and practice models across teams. Multiple studies identified the TRM, PACE (Playfulness, Acceptance, Curiosity and Empathy), ARC (Attachment Regulation, Competency), and related TI frameworks as important tools for maintaining consistency in understanding and responding to behaviour.^{21,25,26}

Communities of practice, cross-site learning events, programme dashboards, and multidisciplinary consultation forums further reinforced fidelity by enabling reflection, shared interpretation, and collaborative problem-solving. Overall, this highlights the importance of shared frameworks in anchoring fidelity, providing a consistent foundation for interpretation, decision-making, and practice across diverse contexts.

3. The balance between fidelity and adaptation

Although most interventions demonstrated fidelity to core principles, nearly all studies reported adaptations made in response to local organisational contexts, workforce pressures, or operational constraints. A consistent finding across studies was that fidelity and flexibility were understood as complementary rather than opposing forces within TI implementation.

Adaptations to delivery formats to support feasibility and access were widely reported, with several interventions modifying delivery formats to accommodate workforce availability and organisational demands. For example, Stepanous et al.,⁴ when evaluating the More Good Days At School (MGDAS) whole-school training programme across 25 intervention schools, reported that schools

frequently shortened or split training sessions, reduced consultation group frequency, and used recorded sessions to improve accessibility. Similarly, Herrera et al.⁶ reported substantial variation in session structure, consultancy arrangements, and training timelines across schools implementing the Trauma Informed Schools UK programme. Baan et al.²⁴ also observed that local authorities adapted scheduling, workshop content, and delivery methods within Fostering Connections to better align with local priorities and workforce capacity. These findings indicate that practical adaptations to delivery are commonly used to enhance feasibility and engagement across varied service contexts.

Trade-offs between flexibility and consistency in implementation were evident: while adaptations improved feasibility and participation, they also introduced variability in dosage, sequencing, and exposure to intervention components. Consistent with this, fidelity tended to be strongest for core training elements but less consistently achieved for implementation support structures and longer-term embedding activities. For example, Fostering Connections achieved strong fidelity in core training delivery, but engagement with wraparound support, pastoral calls, and TI Champion roles was inconsistent across sites.²⁴ Equally, Stepanous et al.⁴ observed that whole-school training attendance was substantially lower than targeted leadership or pastoral sessions, with overall attendance averaging around 29%, reducing consistency in staff exposure.

Adaptation as an expression of trauma-informed principles was also highlighted, with some studies suggesting that flexibility itself reflected TI practice where it responded to participant needs and organisational realities. To illustrate this, Jacob et al.²⁶ found that local implementation models differed substantially across sites. However, fidelity to relational and TI principles remained strong because interventions prioritised responsiveness, emotional safety, and collaborative engagement of children and young people. Likewise, the South East FfIC programmes²⁷ emphasised flexible, formulation-led approaches tailored to family needs while still maintaining alignment with overarching Framework for Integrated Care principles. Therefore, adaptation can reinforce rather than undermine fidelity when it is grounded in core TI values and relational practice.

4. Organisational and systemic barriers to sustained fidelity

Despite generally positive implementation findings, all studies identified organisational and systemic pressures that constrained the sustainability and consistency of high-fidelity implementation. Workforce pressures, competing priorities, staff turnover, and tensions with existing institutional systems were particularly prominent across the evidence base.

Tensions between trauma-informed practice and system demands were consistently reported across youth justice, schools, policing, and social care settings, where practitioners frequently described challenges in reconciling relational approaches with procedural or performance-driven systems.

In school settings, for example, Fancourt and Sebba¹⁷ found that the Attachment Aware Schools Programme supported improved understanding of attachment and trauma. However, sustaining implementation was challenged by competing school priorities, inconsistent follow-through after training, and a lack of formal accountability structures to monitor ongoing delivery. Likewise, in youth justice systems, Facer-Irwin²² reported that staff experienced conflict between maintaining TI practice and meeting statutory requirements, court expectations, and enforcement responsibilities. This reflects broader inconsistencies between TI principles and established youth justice procedures. Similar tensions were identified within the Humber and North Yorkshire programme, where external agencies often prioritised rapid behavioural change and structured interventions over relational engagement.²⁶ Consistent with these findings, Richmond et al.²⁸ reported that rapid discharge processes, limited practitioner time, and procedural demands constrained the consistent application of TI principles among frontline public service workers. These findings highlight that systemic and structural pressures can constrain fidelity, limiting the extent to which TI approaches can be consistently embedded in practice.

Workforce instability and capacity limitations also undermined fidelity across multiple studies. Herrera et al.⁶ reported that staff turnover disrupted continuity and reduced consistency in implementation within schools. Likewise, Coulton et al.¹⁴ identified organisational change and workforce pressures as barriers to maintaining consistent delivery of multi-agency components within RBT. Similar

concerns regarding burnout, increasing demand, and workforce sustainability were reported within the South East FfIC programmes²⁷ and Bond-Taylor et al.,²⁵ where practitioners frequently described “fire-fighting” and crisis management as limiting opportunities to implement TI recommendations fully.

Challenges embedding trauma-informed approaches within established organisational cultures were also evident, as several studies identified difficulties implementing TI practice within systems historically shaped by punitive, compliance-focused, or procedural norms. In policing, McCoy et al.²³ identified barriers, including operational pressures, role ambiguity, and initial scepticism, with some officers perceiving TI approaches as incompatible with traditional enforcement roles or viewing reflective practice as disciplinary scrutiny. School-based studies similarly reported inconsistent staff buy-in and ongoing reliance on punitive behavioural approaches among some practitioners.^{18,29} These findings suggest that sustaining fidelity often required substantial cultural and organisational change beyond initial training delivery.

5. Monitoring, feedback, and fidelity assessment

Approaches to monitoring fidelity varied considerably across studies, ranging from informal reflective mechanisms to structured implementation monitoring systems. Several evaluations incorporated formal adherence tools, programme dashboards, attendance records, or implementation checklists:

- Jacob et al.²⁶ found that fidelity was supported through a structured “hub and spokes” model. This model coordinated training, organisational development tools, ARC Champion agreements, supervision, and communities of practice across sites, alongside dashboards, advisory groups, and staff feedback mechanisms to monitor consistency.
- Herrera et al.⁶ used an adherence tool measuring engagement across five implementation domains.
- Lincolnshire (Complex Needs Service) CNS evaluation²⁵ utilised validated measures including the TICOMETER and the Kirkpatrick evaluation framework.

- Baan et al.²⁴ monitored fidelity through session observations, facilitator records, training feedback surveys, and programme monitoring data assessing content coverage and session aims.

Reflective and feedback-based monitoring approaches were also common. Clinical supervision, communities of practice, reflective journaling, case reviews, and multidisciplinary meetings frequently functioned as ongoing fidelity-monitoring mechanisms. McCoy et al.²³ used body-worn video reviews and safeguarding documentation audits to provide feedback on TI policing practices. Carter,¹⁸ by contrast, utilised coaching sessions and reflective journals to support continuous implementation reflection among school staff implementing trauma-sensitive social and emotional learning activities.

Limitations in formal fidelity monitoring and measurement were evident as several studies noted a lack of structured processes for assessing implementation. Sparling et al.²⁰, when evaluating an Adverse Childhood Experiences (ACE)-informed whole-school programme across primary schools, reported that monitoring relied largely on anecdotal indicators and informal discussion rather than systematic assessment. Cordis Bright²¹ also highlighted challenges documenting relational and developmental work within procedural case-recording systems which may be less well suited to capturing ongoing, process-oriented aspects of practice. Overall, this suggests that fidelity in these approaches is closely tied to relationships and culture, and therefore not easy to capture using standard checklists or formal measures alone.

Intervention providers and training

Intervention providers and training refer to the workforce responsible for delivering TI interventions and the forms of preparation, supervision, consultation, and ongoing professional support provided to enable implementation.

Across the 14 included studies (see Appendix 4), interventions were delivered by a wide range of providers, including youth justice practitioners, social workers, school staff, police officers, psychologists, youth workers, multidisciplinary clinical teams, and external specialist facilitators. Training components commonly aimed to strengthen understanding of trauma, attachment, emotional regulation, and

relational practice. In addition to initial training, ongoing supervision and reflective support were frequently identified as essential mechanisms for sustaining implementation quality and staff wellbeing. These findings indicate that both workforce diversity and continued support structures were central to effective TI implementation.

Four interrelated themes were identified within the evidence:

- 1) The importance of credible and relational delivery;
- 2) Training as a mechanism for legitimising relational practice;
- 3) Variability in implementation linked to workforce engagement and organisational support;
- 4) The importance of supervision and reflective support in sustaining TI delivery.

The following sections of this report examine each of these themes in detail.

1. Credibility, relational delivery, and multidisciplinary expertise

Across the evidence base, participants consistently emphasised the importance of intervention providers being perceived as credible, experienced, and relational in their delivery approach. Interventions delivered by multidisciplinary teams or external specialists were often viewed particularly positively, as they combined technical expertise with opportunities for reflective and collaborative learning.

Multidisciplinary and specialist-led delivery strengthened practitioner confidence and engagement, as illustrated in the Enhanced Case Management (ECM) evaluation conducted by Cordis Bright.²¹ Delivery was shared between Youth Offending Team (YOT) practitioners, managers, and FACTS clinical psychologists. Practitioners valued access to specialist psychological expertise, particularly around trauma, attachment, and developmental needs, while psychologists facilitated multidisciplinary formulation meetings and reflective supervision. Similarly, in their examination of TRM implementation within a Youth Justice Service, Facer-Irwin²² highlighted psychologist-led supervision and formulation work as key contributors to practitioner confidence and sustained engagement with TI approaches. Together, these findings indicate that access to

specialist expertise and reflective support plays an important role in embedding TI approaches in practice.

Facilitator style and modelling of trauma-informed practice were particularly influential in school-based interventions, with studies highlighting the value of facilitators who created psychologically safe environments and demonstrated relational approaches during delivery. In the Trauma Informed Schools UK programme,⁶ staff viewed trainers and consultants as credible when they created safe reflective environments and modelled relational approaches during training itself. Diploma-trained practitioners within schools became important implementation leads, particularly in schools where leadership actively reinforced TI principles. Likewise, Richmond et al.,²⁸ evaluated the trauma awareness training for frontline public service workers and highlighted that participants valued trainers with practical experience who used real-life examples and applied explanations to make psychological concepts accessible and relevant to everyday practice. Participants also emphasised the importance of ongoing support, including supervision and reflective opportunities, to sustain learning. The Attachment Aware Schools Programme¹⁷ similarly benefited from trainers with expertise in attachment and TI practice, alongside staff with lived experience, such as foster carers working within schools, whose contributions were perceived as authentic and impactful.

Integration of clinical and community-based roles supported holistic and responsive delivery, particularly within multi-agency and community interventions. For example, The South East FfIC Vanguard Programmes²⁷ including the Thames Valley Link Programme and Building Belonging Programme integrated clinicians, assistant psychologists, youth workers, and voluntary sector practitioners across health, social care, and youth justice partnerships. Youth workers, particularly in the Thames Valley Link Programme, were repeatedly identified as central to successful engagement because of their ability to work persistently, flexibly, and relationally with young people in community settings. Similarly, Jacob et al.,²⁶ when evaluating the Humber and North Yorkshire Children and Young People's Trauma Informed Care Programme, highlighted the importance of embedded specialist roles, including psychologists, speech and language therapists, TI practitioners, and voluntary sector staff, in enabling

holistic and responsive support and reducing delays linked to mainstream waiting lists. In East Riding, for example, staff explained that embedded speech and language expertise prevented children and young people from remaining unsupported for “another year or 18 months” while waiting for mainstream services. The evaluation also identified wider workforce development and system diffusion, with programme teams providing consultation and training to external professionals across education, policing, and social care. This was supported by communities of practice, supervision networks, and ARC Champion structures, which helped reinforce shared learning and TI approaches across systems. These findings suggest that combining clinical expertise with community-based roles enhances responsiveness, engagement, and system-wide capacity for TI care.

External specialists added value through independence and experiential expertise, particularly in policing and social care contexts. In the Trauma Informed Policing Programme,²³ Trauma Informed Practitioners employed externally by Rock Pool brought expertise in trauma-informed practice, domestic abuse, and working with individuals experiencing crisis and complex needs. They were regarded as particularly valuable because their independence enabled them to challenge policing culture while maintaining supportive relationships with officers. In the Fostering Connections trial,²⁴ social workers described the multidisciplinary delivery team as approachable, engaging, and credible. This was attributed in part to facilitators combining professional expertise with lived experience perspectives and using experiential learning approaches rather than traditional didactic teaching.

Variation in reliance on external versus internal delivery had implications for consistency and sustainability with some interventions, such as ECM,²¹ TRM,²² and the policing programme,²³ maintaining strong ongoing involvement from psychologists or specialist practitioners throughout delivery. In contrast, several school-based interventions, including ACE Informed Schools²⁰ and Attachment Aware Schools,¹⁷ relied more heavily on schools sustaining implementation internally following initial training. These differences appeared to have implications for both the implementation consistency and sustainability of the intervention programme. This suggests that while external support can enhance

fidelity and depth of implementation, longer-term sustainability may depend on successfully embedding capacity within existing systems.

2. Training as validation and legitimisation of relational practice

Training was frequently described as reinforcing and legitimising relational, child-centred practice, helping practitioners to reframe behaviour through a trauma-informed lens and supporting wider shifts in professional culture.

Training as legitimisation of relational and child-centred practice was a consistent finding across studies, with TI training often reinforcing and validating approaches that practitioners already valued but felt constrained from using within existing organisational or system structures. In both ECM²¹ and TRM,²² practitioners described the training as providing “permission” to move away from rigid offence-focused interventions and towards more relational and individualised work with young people. Staff reported that TI frameworks validated practices such as relationship-building, emotional safety, consistency, and developmental responsiveness. These were approaches they had previously struggled to justify within procedural youth justice environments.

Shifts in understanding behaviour within education settings were similarly reported across school-based studies. Staff participating in Attachment Aware Schools,¹⁷ ACE Informed Schools,²⁰ More Good Days At School,⁴ and Carter’s¹⁸ alternative high school Trauma Informed Care (TIC) programme all reported shifts in understanding pupil behaviour through TI and relational lenses. Training encouraged staff to reinterpret behaviour as communication of unmet need or dysregulation rather than deliberate defiance. In Carter,¹⁸ newer teachers often described particularly significant shifts in perspective, while more experienced counsellors tended to view training as extending existing knowledge.

Transformational impacts of training across wider systems were also evident in broader, multi-agency initiatives. Jacob et al.²⁶ found that TI training across health, education, youth justice, social care, and policing systems contributed to what one participant described as “a new age of practitioner.” This was characterised by more relational, less formal, and more psychologically informed approaches. Staff reported that TI training and consultation strengthened their

theoretical understanding of trauma, increasing confidence in explaining behaviour and advocating for relational approaches. Similarly, Bond-Taylor²⁵ found that consultation enhanced practitioners' ability to promote TI practice within wider professional networks. Likewise, police officers participating in the Trauma Informed Policing Programme²³ reported that training encouraged them to think differently about behaviour, vulnerability, and safeguarding interactions with children and young people. Importantly, this indicates that training can contribute to broader cultural and professional shifts across systems, extending beyond individual practice changes.

Limitations of training without ongoing support were also evident as training, while valued by participants, was insufficient in isolation to achieve lasting practice change. Instead, interventions appeared most effective where training was reinforced through reflective supervision, consultation, coaching, communities of practice, or multidisciplinary collaboration.

3. Variability in workforce engagement, confidence, and organisational support

Across studies, the effectiveness of trauma-informed implementation varied according to workforce engagement, confidence, and organisational support. While training was generally well received, sustained implementation often depended on factors such as leadership commitment, staff readiness, role clarity, and organisational capacity.

Variation in implementation quality linked to workforce engagement and organisational capacity was evident, although most studies reported overall positive perceptions of TI training. Across settings, the extent to which training translated into practice varied according to staff engagement, leadership support, role clarity, and wider organisational capacity. In school settings, for example, Fancourt and Sebba¹⁷ reported that while the Attachment Aware Schools Programme increased staff confidence and understanding of attachment, trauma, and behaviour across a range of roles, the quality and consistency of implementation depended on staff engagement and their capacity to embed learning beyond initial training. Similarly, Sparling et al.²⁰ highlighted that while

ACE-informed training was often viewed as relevant and transformative, perceptions of quality varied. Specifically, some staff viewed the content as overly theoretical, with implementation constrained in schools where leadership capacity and internal support structures were weaker. Staff stressed the need for ongoing support, peer discussion, and practical guidance to sustain implementation in complex classroom contexts.

Inequalities in access to training as a barrier to consistent implementation were also identified, as differences in access were highlighted across several studies. Within ECM,²¹ not all managers or practitioners were able to attend formal training because of limited spaces and competing organisational pressures. Practitioners noted that managers who had not attended training often demonstrated lower understanding and confidence regarding TI approaches, which sometimes weakened implementation support. Stakeholders therefore emphasised the importance of wider access to training in any future roll-out, particularly for managers, to strengthen organisational consistency and support effective oversight of TI practice. Similarly, Herrera et al.⁶ reported that implementation quality in schools depended heavily on leadership participation and reinforcement of TI principles within wider school systems.

Whole-system approaches supporting shared responsibility and consistency in practice were emphasised, with the promotion of shared language and collective responsibility within whole-school or whole-organisation approaches generally viewed as beneficial. In More Good Days At School,⁴ schools with proactive senior leadership teams and established wellbeing infrastructures were better able to support staff attendance and maintain engagement and implementation momentum. Participants reported that whole-school delivery fostered consistency across teaching, pastoral, and leadership staff fostering collective responsibility for supporting pupils. Carter¹⁸ likewise found that staff valued whole-school professional development because it improved consistency of practice and school climate.

Differences in workforce engagement and readiness across professional roles were apparent, with engagement often varying between groups. Herrera et al.⁶ reported that pastoral, SEND, and wellbeing staff tended to engage more strongly with TI programmes than classroom teachers, some of whom initially viewed

implementation as an additional burden. Likewise, Stepanous et al.⁴ found that staff engagement was lower in some schools where competing priorities limited attendance or where leadership support was less visible. Facer-Irwin²² similarly observed differences in practitioners' readiness to adopt relational and reflective approaches, with some youth justice staff expressing uncertainty about whether trauma-focused conversations fell within their professional remit. In contrast, Bond-Taylor²⁵ found relatively consistent perceptions of intervention quality across job roles and seniority within a multi-agency service. However, more experienced staff reported slightly lower perceived usefulness, potentially reflecting prior exposure to TI approaches.

Role ambiguity and boundary concerns as challenges to implementation were also highlighted, with studies identifying tensions regarding roles and expectations. In Facer-Irwin,²² some practitioners worried they were being expected to undertake therapeutic work without sufficient expertise. Comparable concerns emerged in policing, where some officers initially misunderstood reflective sessions with Trauma Informed Practitioners as performance monitoring processes.²³ In Fostering Connections,²⁴ implementation of TI Champion roles varied considerably across local authorities, with some participants reporting uncertainty about responsibilities and expectations. This highlights the importance of clearly defining roles and expectations when embedding TI approaches within existing systems.

4. Supervision, reflective practice, and workforce wellbeing

Across studies, supervision, reflective practice, and workforce wellbeing were identified as important factors in supporting the implementation and sustainability of trauma-informed approaches. The evidence-base highlighted the role of ongoing reflective support in maintaining practice quality, embedding trauma-informed principles, and helping practitioners manage the emotional demands of their work.

Reflective supervision and ongoing support were consistently identified across studies as a central component of implementation quality and fidelity, supporting staff wellbeing and sustaining TI practice. In the ECM²¹ and TRM²² evaluations,

psychologist-led reflective supervision was viewed as one of the most valuable elements of implementation. Practitioners highlighted the value of access to specialist expertise and reflective discussions regarding complex cases allowing them to think more carefully about underlying need, intervention sequencing, and relational engagement. Facer-Irwin²² reported that practitioners preferred reflective supervision delivered by psychologists independent of management structures. Where this was replaced with managerial supervision in the wider service roll-out, staff felt the reflective and supportive quality was diminished. They raised concerns that performance-focused oversight could not replicate psychologically informed supervision and risked diluting TI practice.

Emotional demands of trauma-informed work and the importance of staff support were recurring themes across multiple sectors. Youth justice practitioners in Facer-Irwin²² described experiences consistent with secondary traumatic stress, burnout, and emotional exhaustion. Similarly, Coulton et al.,¹⁴ evaluating the RBT model across multiple youth services, highlighted the emotional intensity and relational demands of TI delivery, with staff emphasising the importance of ongoing supervision, reflective support, and organisational backing to sustain practice quality. Police officers in McCoy et al.²³ similarly valued opportunities to debrief difficult incidents with Trauma Informed Practitioners, who often filled perceived gaps in organisational welfare provision by offering confidential emotional support, reflective conversations, and signposting to additional services. Richmond et al.,²⁸ evaluating trauma awareness training for frontline public service workers, likewise reported strong demand for ongoing supervision and opportunities to “offload” after traumatic interactions.

Reflective consultation and coaching supporting the embedding of TI practice were highlighted in several studies as important for translating training into everyday practice. In Carter’s¹⁸ school-based TIC programme, weekly coaching and collaborative reflection sessions were viewed as essential for sustaining implementation and improving staff confidence. Within the Lincolnshire CYP Complex Needs Service evaluation,²⁵ consultation and reflective formulation processes helped staff feel less “stuck” in complex cases and strengthened confidence in advocating for TI approaches. McCoy et al.²³ further highlighted that the ongoing involvement of Trauma Informed Practitioners also helped translate

training into practice, with officers reporting that TI thinking became internalised during operational decision making. This highlights the value of ongoing reflective support in embedding TI thinking into routine practice and decision making.

Workforce constraints as barriers to sustaining supervision and reflective support were nonetheless identified across several studies. This included challenges in due to workforce pressures, staffing shortages, and limited clinical capacity. In the South East FfIC programmes²⁷ disparities in employment conditions, staff retention difficulties, and limited progression opportunities threatened continuity of TI delivery. For instance, youth workers highlighted limited career progression pathways and the need for greater continuing professional development opportunities. Workforce sustainability concerns were also evident in Cordis Bright²¹ where access to clinical supervision varied across sites because of logistical and workforce constraints within FACTS. Similarly, Herrera et al⁶ found staff turnover also affected continuity of the TI approach, particularly where trained practitioners left and were not replaced or where new staff were not systematically inducted into the approach. Collectively, these findings highlight workforce capacity and continuity as key challenges for sustaining TI practice over time.

Reach and penetration

Reach refers to the proportion and representativeness of the target population that participates in or is exposed to an intervention, while penetration refers to the extent to which an intervention becomes integrated within organisational systems, routine practice, or wider service settings.

Across the 14 included studies (see Appendix 4), TI interventions generally demonstrated strong reach into populations characterised by high levels of adversity, complexity, and unmet need. However, penetration into wider organisational and interagency systems was more variable, with many studies identifying uneven implementation, workforce pressures, and limited system-wide embedding as key constraints.

Four interrelated themes were identified within the evidence:

- 1) Reaching vulnerable and underserved populations;
- 2) Participation, engagement, and attrition;

- 3) Organisational penetration and embedding within practice;
- 4) Workforce capacity, implementation intensity, and sustainability.

The following sections of this report examine each of these themes in detail.

1. Reaching vulnerable and underserved populations

Studies consistently found that TI interventions frequently reached children and young people with complex psychosocial needs. This included histories of trauma, exploitation, offending, school exclusion, neurodevelopmental difficulties, and mental health difficulties. Several evaluations also explicitly highlighted that interventions were engaging groups who were less well served by traditional systems or who faced barriers to accessing thresholds for statutory support.

Engagement of underserved and high-risk populations was a key strength particularly in targeted and multi-agency interventions. Notably, the Enhanced Case Management (ECM) model evaluated by Cordis Bright²¹ successfully engaged young people with extensive offending histories and overlapping vulnerabilities, including domestic abuse exposure, substance misuse, self-harm, family instability, and disrupted relationships. Additionally, risk assessments indicated average levels of reoffending risk within the medium range, while average vulnerability scores fell between “medium” and “high.” Similarly, the Humber and North Yorkshire Trauma Informed Care Programme²⁶ was repeatedly described by stakeholders as reaching children and young people who were underserved or who would otherwise receive little or no support, including those at risk of exploitation, school exclusion, offending, or disengagement from mainstream services. This included children and young people who would not typically meet thresholds for Child and Mental Health Services (CAMHS) or other commissioned interventions or were unable to engage with these services because of the complexity of their circumstances. The South East FfIC Vanguard programmes²⁷ also demonstrated strong reach into populations described as falling through the gaps of existing statutory provision, particularly children with intersecting mental health, safeguarding, and social vulnerabilities.

Multi-agency referral pathways supported broader system reach, although the scale of referral systems varied considerably. Bond-Taylor's²⁵ evaluation of the Lincolnshire Complex Needs Service (CNS) analysed 1,636 active cases referred

from youth justice, social care, NHS services, housing, police, and self-referral routes, indicating broad penetration across multiple sectors. Likewise, the Thames Valley Link Programme²⁷ received referrals from CAMHS, education, police, youth justice, social care, and voluntary organisations, reflecting strong integration within local professional networks.

Variation in scale and delivery models influenced overall reach, with some interventions operating at a smaller scale or within narrower systems. For example, Cordis Bright²¹ involved 21 young people across three Youth Offending Teams following revised eligibility criteria, while the Building Belonging Programme²⁷ reached 67 young people despite aiming to support substantially larger numbers (286). These differences suggest that interventions with broader partnership infrastructures and flexible referral pathways were often able to achieve wider reach, whereas more targeted or intensive interventions sometimes struggled to expand participation despite positive engagement among those enrolled.

School-based interventions reached vulnerable pupil populations through universal and targeted approaches particularly those experiencing social, behavioural, and emotional difficulties. The More Good Days At School (MGDAS) programme⁴ was perceived as particularly relevant in schools serving pupils affected by disadvantage, mental health difficulties, and adverse childhood experiences. Carter's¹⁸ evaluation of a TI programme in an alternative high school involved students with behavioural challenges, exclusion histories, and documented special educational needs. In the Attachment Aware Schools Programme,¹⁷ whole-school delivery enabled exposure to attachment-aware approaches across a large proportion of school staff and vulnerable pupil populations.

Selection effects and organisational readiness shaped participation in school-based programmes, with some initiatives more likely to engage settings already oriented toward wellbeing and inclusion. Sparling et al.²⁰ reported that schools involved in the ACE Informed Schools initiative were selected partly on the basis of organisational readiness and alignment with TI principles. While this may have strengthened implementation, it may also have limited how representative participating schools were.

Limitations in inclusivity and representativeness were also identified despite overall strong reach. Jacob et al.²⁶ reported that the majority of participants accessing the Humber and North Yorkshire programme were white British males aged 13–15 years, raising concerns regarding whether some groups remained underserved. Similarly, the Lincolnshire CNS evaluation²⁵ identified underrepresentation of children and young people from ethnic minority backgrounds within several referral profiles. These findings suggest that even interventions demonstrating substantial organisational reach may continue to face challenges in equitably engaging diverse populations.

2. Participation, engagement, and attrition

Across studies, relational and flexible approaches to engagement were consistently identified as central facilitators of sustained participation. Multiple evaluations reported that TI approaches improved practitioners' ability to engage children and young people who had historically been viewed as hard to reach, non-compliant, or resistant to services.

Relationship-based practice supporting sustained participation and reduced attrition was particularly evident in several interventions. The ECM evaluation²¹ reported very low levels of attrition, with stakeholders suggesting that no participants withdrew because they no longer wished to engage. Practitioners linked sustained participation to the strength of relational practice and the constructive relationships developed with young people. Similarly, Facer-Irwin²² found that practitioners increasingly conceptualised disengagement as relational and contextual rather than as individual non-compliance, leading staff to adopt more persistent and adaptive engagement strategies. Young people and families particularly valued practitioners who maintained consistent support despite setbacks or challenging behaviour. Relationship-based practice was also central within the Relationship Building Together (RBT) evaluation,¹⁴ where stable and trusting practitioner relationships were described as essential to sustaining participation and perceived benefit. Across the South East FfIC programmes,²⁷ flexible consultation models and relationship-based approaches were similarly

viewed as critical for engaging children who struggled to access conventional statutory services.

Variation in sustained engagement was shaped by workforce and organisational factors with studies showing that participation was not always maintained over time, even where relational practice was prioritised. Some interventions demonstrated relatively stable engagement despite working with highly vulnerable populations, whereas others experienced significant barriers linked to workforce instability, organisational pressures, or inconsistent implementation. In the Fostering Connections programme,²⁴ social worker turnover and placement instability limited opportunities for sustained relationship-based work, while workload pressures contributed to poor attendance at training sessions. Similarly, the MGDAS⁴ evaluation reported variation in staff participation due to competing workload pressures, particularly among teaching staff outside pastoral or leadership roles. Carter¹⁸ also identified inconsistent staff participation and student transience within the alternative school setting as barriers to maintaining a coherent whole-school TI approach. This highlights that, while relational approaches are critical, their effectiveness is contingent on stable workforce conditions and supportive organisational environments.

Challenges engaging participants in evaluation and co-production activities were also reported across studies. Facer-Irwin²² noted challenges recruiting young people and parents because of emotional vulnerability, instability, gatekeeping behaviours, and practitioner concerns regarding risk. Similar challenges were identified in the Lincolnshire CNS evaluation,²⁵ where difficulties involving children and young people in co-production and evaluation activities prompted the development of new participation strategies. This suggests that meaningful participation in evaluation and co-production may require additional time, trust-building, and tailored approaches to engagement.

3. Organisational penetration and embedding within practice

A major theme across studies concerned the extent to which TI principles became embedded within routine organisational systems and cultures. While many interventions achieved at least partial penetration into practice, the depth,

consistency, and sustainability of embedding varied substantially both within and across sectors.

Evidence of strong organisational integration was reported in several studies. In the Humber and North Yorkshire programme,²⁶ TI approaches became embedded across induction systems, supervision structures, policing initiatives, organisational toolkits, and cross-sector strategic partnerships. Communities of practice, NHS Futures platforms, and Strategic Alliance structures supported ongoing cross-sector integration and collaboration. Similarly, the Lincolnshire CNS evaluation²⁵ found that staff were applying TI principles not only within direct interventions, but also in assessments, work with parents and carers, communication practices, and multi-agency meetings. Participants described TI thinking as increasingly normalised within routine service processes. In the Trauma Informed Policing Programme,²³ officers working directly with Trauma Informed Practitioners described them as becoming “part of the team,” with reflective practice and TI reporting increasingly integrated into day-to-day policing activity. Evidence of sustained but more individual-level embedding was also found by Richmond et al.,²⁸ where participants continued to apply TI concepts, such as the “window of tolerance” and TI communication strategies, several months after their one-day Trauma Awareness Training workshop. Frontline public service workers described incorporating learnt concepts into assessments, interactions, and psychoeducational work, although wider organisational structures sometimes limited deeper integration (e.g., limited managerial support, insufficient opportunities for supervision). Taken together, these findings indicate that deep embedding is achievable where TI approaches are integrated across systems, structures, and everyday practice.

Variation in embedding within school-based interventions was also evident, with some settings demonstrating deep integration while others showed more limited or fragmented implementation. To illustrate, Herrera et al.⁶ found that, in some schools, TI approaches became integrated into behaviour systems, referral processes, classroom routines, and physical environments. In contrast, other schools demonstrated limited penetration with implementation characterised by isolated pockets of practice rather than whole-school change. Both MGDAS⁴ and the Attachment Aware Schools Programme¹⁷ reported integration into

safeguarding systems, pastoral support, behaviour management, and emotional regulation practices in some settings. Similarly, Carter¹⁸ described embedding through daily emotional check-ins, mindfulness activities, restorative approaches, and trauma-sensitive classroom environments.

Leadership support as a key determinant of system-wide embedding was consistently highlighted across studies. Schools and services where senior leaders actively endorsed TI principles were more likely to demonstrate coherent whole-system implementation. Herrera et al.,⁶ Fancourt and Sebba,¹⁷ and Sparling et al.²⁰ all highlighted the importance of leadership alignment, strategic prioritisation, and organisational readiness in supporting embedding and sustainability. By contrast, implementation appeared weaker where TI approaches were insufficiently integrated into formal organisational procedures or where managerial support was inconsistent. Facer-Irwin,²² for example, found that the extent of implementation varied depending on supervision access, leadership support, and competing organisational demands, while Carter¹⁸ identified lack of buy-in from some disciplinary staff as a barrier to wider penetration. This evidence suggests that consistent senior leadership support, combined with integration into organisational systems, supports sustained, system-wide embedding.

Stronger embedding within core teams than across wider systems was a recurring pattern across studies. In Facer-Irwin,²² TI principles were more firmly embedded within teams involved in the original Trauma Recovery Model pilot than within newer teams included during wider roll-out. Similarly, McCoy et al.²³ found strong integration of Trauma Informed Practitioners within designated policing teams but relatively low awareness across the wider constabulary. Cordis Bright²¹ demonstrated strong uptake among practitioners directly involved in delivery, particularly those receiving specialist training and supervision. However, multidisciplinary engagement from partner agencies (e.g., housing, CAMHS) often reduced over time because of competing demands and limited capacity.

Penetration beyond immediate intervention settings was particularly challenging in multi-agency contexts. Several studies described fragmentation between youth justice, education, social care, healthcare, policing, and custodial systems, each operating according to different priorities and organisational

cultures. Facer-Irwin²² reported frustration among practitioners that TI work within youth justice services was often undermined by punitive or inconsistent responses from external agencies. Similar challenges emerged within the South East FfIC programmes²⁷ and the Humber and North Yorkshire programme,²⁶ where stakeholders highlighted variability in awareness, referral pathways, and shared TI practice across agencies despite broader strategic ambitions for system integration. These findings suggest that cross-agency misalignment remains a significant barrier to achieving consistent, system-wide TI practice.

4. Workforce capacity, implementation intensity, and sustainability

Workforce capacity constraints emerged as one of the most consistent barriers limiting both reach and penetration. Across sectors, staff shortages, turnover, competing professional demands, and high caseloads reduced participation in training, limited implementation consistency, and constrained opportunities for sustained organisational embedding.

Reduced participation due to workload and competing demands limiting implementation depth was evident across multiple studies. In *Fostering Connections*,²⁴ only 42% of social workers met the training attendance requirements due largely to workload pressures, sickness absence, court attendance, and competing responsibilities. Engagement with supplementary implementation supports beyond the core components, including e-learning modules and communities of practice, was also consistently low. Many foster carers and social workers reported being unaware of these resources or unclear about how to access them. Low participation reduced the extent to which TI principles became embedded within routine organisational systems and limited opportunities for sustained peer learning and reinforcement of training content. Similar patterns were identified within the Attachment Aware Schools Programme,¹⁷ where uptake of optional online learning was limited (4 out of 24 schools), and within the ACE Informed Schools initiative,²⁰ where staffing pressures restricted attendance at after-school training. These findings contrasted with interventions that achieved broader organisational participation through integrated delivery structures, such as the Trauma Awareness Training evaluated

by Richmond et al.,²⁸ which reached a broad range of frontline public sector workers across local services.

Capacity limitations affecting visibility, referral pathways, and sustainability

were also widely reported. The South East FfIC (Community) Vanguard Programme²⁷, including the Thames Valley Link Programme, illustrate these challenges. Stakeholders reported inconsistencies in awareness across agencies and geographical areas, confusion around eligibility criteria, and barriers embedding referral pathways, particularly within the Children's Single Point of Access. Participants also highlighted the need for greater networking, promotion, and strategic buy-in to strengthen integration. Within this context, the Thames Valley Link Programme identified concerns regarding rising caseloads and the sustainability of intensive relationship-based support, with youth worker caseloads approaching maximum levels. Similarly, Jacob et al.²⁶ reported that some sites deliberately reduced publicity because demand exceeded staffing capacity. McCoy et al.²³ noted that the small number of Trauma Informed Practitioners limited wider exposure across policing teams. Across several studies,^{18,22,23,28,29} stakeholders expressed concern that without continued supervision, protected implementation time, and sustained strategic investment, TI practice risked remaining superficial or diminishing over time. Together, this shows that capacity constraints can limit visibility, referral pathways, and sustainability, reducing both reach and depth of implementation without ongoing support.

Adaptations for equity-related characteristics

Adaptations for equity-related characteristics refer to deliberate modifications to intervention delivery intended to improve accessibility, acceptability, and effectiveness for populations with differing needs and circumstances while maintaining the intervention's core components.

Across the 14 included studies (see Appendix 4), adaptations were rarely implemented as formal, pre-specified responses to protected characteristics such as ethnicity, disability, gender, or socio-economic deprivation. Instead, adaptations were more commonly framed through TI principles of

individualisation, flexibility, and responsiveness to participants' developmental, emotional, and contextual needs.

Four overarching themes were identified across studies:

- 1) Individualised and relational adaptations;
- 2) Adaptations to improve accessibility and participation;
- 3) Emerging attention to cultural responsiveness and structural inequalities;
- 4) System- and context-driven adaptation.

The following sections of this report examine each of these themes in detail.

1. Individualised and relational adaptations

A consistent finding across studies was the adaptation of intervention delivery to the individual needs, experiences, and readiness of participants. Rather than relying on standardised intervention pathways, many programmes emphasised flexible and tailored approaches designed to accommodate trauma histories, developmental functioning, emotional regulation difficulties, communication needs, and family circumstances.

Adaptations to individual needs were particularly evident in TI youth justice interventions. Both the Enhanced Case Management (ECM) model²¹ and the Trauma Recovery Model (TRM) implementation examined by Facer-Irwin²² used detailed case formulation processes to identify underlying needs and adapt intervention content, pacing, and delivery accordingly. In the ECM evaluation,²¹ practitioners reported that formulations frequently uncovered previously unidentified trauma, bereavement experiences, learning difficulties, and developmental needs. This informed intervention planning including allocation of specific workers to young people and additional assessments. For instance, intervention plans included actions such as requesting follow-up assessments to better understand learning difficulties, incorporating psychoeducation to help young people understand their experiences (including grief), and identifying cognitive functioning, social functioning, and emotional development issues that influenced how practitioners worked with young people. Similarly, TRM practitioners²² reported modifying communication styles, expectations, and

engagement strategies according to young people's emotional readiness and trust in professionals. This often included avoiding potentially stigmatising terminology such as "trauma" or "therapy" where this was perceived as a barrier to engagement. Instead, practitioners often framed the work in terms of understanding behaviour, improving relationships, or helping young people feel safer and more supported.

Comparable patterns were observed across educational and community settings. The Attachment Aware Schools Programme¹⁷ encouraged staff to adapt behavioural responses, communication approaches, and emotional support strategies for pupils experiencing attachment difficulties, trauma, or emotional insecurity. Likewise, Carter,¹⁸ working within an alternative high school serving students with exceptionalities and behavioural challenges, described extensive adaptation of trauma-sensitive social and emotional learning activities. This included flexible participation options, one-to-one support, sensory tools, creative activities, and alternative communication methods (e.g. journaling). In both studies,^{17,18} practitioners viewed these adaptations as essential for maintaining emotional safety and engagement.

Relational flexibility as a key enabler of engagement was highlighted across multiple interventions. Relationship Building Together,¹⁴ the Humber and North Yorkshire Trauma Informed Care Programme,²⁶ and the South East FfIC Vanguard Programmes²⁷ all reported adapting support around participants' preferences, circumstances, and levels of trust. Young people valued having control over the timing, location, pace, and content of sessions. In line with this, practitioners frequently modified approaches to maintain engagement among individuals who had previously struggled to access or remain involved with services. Similarly, Richmond et al.²⁸ found that training increased practitioners' awareness of the need to adapt communication and engagement strategies to individual vulnerabilities. This included greater attention to non-verbal cues, trigger awareness, and more flexible approaches to working with individuals previously labelled as "non-engaging." This indicates that relational flexibility supports engagement by enabling services to respond dynamically to individual needs and preferences.

Limited attention to equity within adaptation processes was also noted despite strong evidence of person-centred delivery. Consequently, while interventions appeared responsive to heterogeneity within populations, there was limited evidence that adaptation processes systematically addressed inequalities associated with ethnicity, gender, SEND, or socio-economic deprivation. This highlights a crucial gap in the evidence, suggesting that while adaptation is practised, it is not yet systematically applied to address broader issues of equity and inclusion.

2. Adaptations to improve accessibility and participation

Across studies, adaptations were commonly made to improve accessibility, participation, and engagement in trauma-informed interventions. These adaptations addressed practical, organisational, and communication barriers, helping to support participation while maintaining the core aims of the intervention.

Adaptations to delivery formats to improve accessibility and participation were evident across studies, with interventions modifying delivery to address practical barriers and organisational constraints. Several school-based and workforce-focused interventions modified delivery formats to accommodate organisational constraints and participant availability. More Good Days at School⁴ adapted session timing, duration, and format through twilight sessions, split workshops, shorter sessions, and online delivery options. Activities and examples were also tailored to reflect the roles of different staff groups, ensuring that teaching, pastoral, and non-teaching staff could engage with content relevant to their responsibilities. Similarly, the Trauma Informed Schools UK programme⁶ employed blended delivery approaches and shorter training formats to improve accessibility for staff with competing responsibilities. Fostering Connections²⁴ also adapted session structures in response to workforce pressures, attendance challenges, and technological barriers. For instance, facilitators commonly adapted session timing, shortened or merged activities, or omitted exercises when sessions started late or participants arrived late or needed to leave early.

Targeted adaptations to meet communication and inclusion needs were particularly prominent in settings where specific barriers had been identified. The Lincolnshire CYP Complex Needs Service (CNS) Phase II evaluation²⁵ described adaptations to outcome measurement with co-production groups adapting scales through simplified language, visual supports, emojis, and input from speech and language specialists. Staff also reported using sensory supports, Talking Mats, visual tools, and adapted communication approaches to facilitate participation among young people with regulation needs and communication difficulties. Similarly, Jacob et al.²⁶ described co-production approaches within the Humber and North Yorkshire programme, where young people contributed to training materials, engagement strategies, and service design. This included the development of resources addressing racism, LGBTQIA+ experiences, and communication needs. These represent some of the clearest examples of adaptations explicitly addressing accessibility and inclusion within the evidence base.

Adaptations to recruitment, eligibility, and engagement processes to widen access were also reported across several interventions. The ECM evaluation²¹ expanded eligibility requirements in response to declining youth justice caseloads, enabling access for young people earlier in their offending trajectories. Similarly, the Humber and North Yorkshire programme²⁶ and the Building Belonging Programme²⁷ revised referral pathways and eligibility processes in response to implementation challenges and inappropriate referrals. In addition, Facer-Irwin²² described relational adaptations to engagement processes, with practitioners emphasising consistent, flexible, and relationship-based approaches. This included the use of trusted case workers to facilitate introductions and support early interactions to build safety and trust with young people. Jacob et al.²⁶ further highlighted adaptations to delivery settings and practical support, with staff selecting locations based on young people's emotional needs and preferences and, where necessary, providing transport to reduce participation barriers for families facing financial or logistical constraints. Additional adaptations included ongoing revisions to referral pathways, particularly within the Children's Single Point of Access (C-SPA), as well as the use of interim workarounds within local authority case management systems to

enable delivery within existing structures.²⁷ While primarily operational, these adaptations had implications for equity by influencing who could access TI support.

3. Cultural responsiveness and structural inequalities

While explicit adaptations for ethnicity, culture, language, gender, or socio-economic disadvantage were relatively uncommon, several studies identified important gaps and opportunities in relation to cultural responsiveness and structural inequalities.

Concerns regarding cultural relevance and applicability of TI frameworks were most clearly articulated in evaluations that examined cultural appropriateness directly. In *Fostering Connections*,²⁴ stakeholders reported on the programme's reliance on Western psychological frameworks. They also highlighted challenges in applying TI approaches across different cultural contexts, particularly when working with unaccompanied asylum-seeking children and families with limited English proficiency. Participants suggested that future delivery should incorporate greater consideration of racial trauma, culturally specific understandings of healing, and linguistic diversity. Similarly, the *Trauma Informed Schools UK* evaluation⁶ reported concerns that programme content insufficiently addressed racial trauma and cultural difference, reducing relevance for some staff from minority ethnic backgrounds. It also suggested that targeted support allocation often relied on informal pastoral judgement rather than transparent criteria, increasing the likelihood that support was concentrated on pupils with more severe needs rather than delivered preventatively.

Emerging integration of equity-related concepts within training and practice was evident in some interventions, particularly in the *Trauma Informed Policing Programme*.²³ Training content encouraged officers to consider racism, cultural background, historical trauma, and social disadvantage as factors shaping behaviour and interactions with services. Survey findings demonstrated increased agreement with statements relating to understanding racism as trauma, recognising historical trauma, and acknowledging cultural differences as important components of trauma-informed practice following training. Despite

this, stakeholders also identified continuing gaps in confidence regarding racialised trauma, cultural inclusion, and communication with children and young people within the force, indicating that further adaptation and development may be needed to strengthen equity-informed implementation.

Recognition of broader structural inequalities shaping outcomes and

engagement was also highlighted across several studies. Facer-Irwin²² reported that practitioners consistently identified poverty, unstable housing, criminal exploitation, neighbourhood violence, and systemic discrimination as factors shaping young people's experiences and responsiveness to intervention. Practitioners also highlighted concerns that wider systems, including children's homes, schools, police, and courts, could perpetuate stigma, criminalisation, and discrimination. This was seen as limiting the effectiveness of TI approaches delivered within the youth justice system alone. Similarly, the Attachment Aware Schools evaluation¹⁷ identified tensions between attachment-informed responses and special educational needs systems. The Lincolnshire CNS evaluation²⁵ also found gender differences in adversity profiles and referral pathways. Female participants were more likely to report experiences such as sexual abuse and exploitation, whereas male participants were more commonly represented within youth justice pathways, suggesting a need for gender-sensitive responses.

Although awareness of structural disadvantage was evident across several studies, formal equity-focused adaptation frameworks were largely absent. Consequently, interventions often recognised inequalities without systematically adapting delivery to address them.

4. System- and context-driven adaptation

Across studies, adaptations were introduced in response to local contexts, organisational structures, implementation challenges, and changing external conditions.

Designed flexibility to support localisation across diverse contexts was evident in many interventions. The ACE Informed Schools model²⁰ encouraged schools to adapt implementation according to existing provision, organisational culture, and community context. Similarly, the Humber and North Yorkshire programme²⁶

demonstrated substantial variation across sites, with local adaptations reflecting differing workforce structures, referral systems, population needs, and organisational priorities. For example, some sites prioritised direct work with children and young people, whereas others focused more on supporting parents and carers and addressing intergenerational trauma, including targeted work with caregivers or embedding specialist roles such as speech and language support to meet specific local needs.

The South East FfIC Vanguard Programmes²⁷ provided one of the clearest examples of adaptive implementation. Delivery models were modified in response to geographical context, funding constraints, governance requirements, workforce capacity, and emerging learning. The Thames Valley Link Programme used phased implementation and adapted youth worker allocation according to gender, trauma histories, lived experience, and neurodevelopmental needs. Building Belonging similarly revised eligibility criteria and referral pathways in response to commissioner priorities and implementation experience.

Responsiveness to changing external conditions as a feature of TI delivery was also demonstrated across programmes. For example, Fostering Connections²⁴ introduced additional reflective activities during periods of social unrest and riots, enabling participants to process the emotional impact of current events. Such adaptations reflected the broader TI principle of responsiveness to context while preserving core intervention components.

Adaptations were often reactive rather than strategically planned. ^{4,6,21,24,26,27}

Adaptations were often introduced to address workforce shortages, funding pressures, referral challenges, governance barriers, or implementation difficulties rather than as part of planned equity strategies. While this flexibility supported feasibility and sustainability, it also contributed to variability in implementation and, in some cases, uncertainty regarding consistency and fidelity.

Delivery characteristics

Delivery characteristics encompass delivery method, delivery setting, and duration or dosage of the intervention.

To briefly summarise, key themes from this section highlight that for TI Training and Service Redesign programmes to be most effective, the following should be established during implementation:

- Relational, trust-based delivery is a primary mechanism of engagement and effectiveness with consistent, non-judgemental interactions and strong therapeutic alliances central to participant engagement and outcomes.
- Flexible and individualised delivery approaches are critical enabling interventions to respond to developmental readiness, complex needs, and contextual factors, though this can introduce variability and reliance on practitioner judgement.
- Interactive, experiential, and practice-oriented methods enhance learning and implementation, particularly where training links theory to real-world scenarios through discussion, reflection, and applied activities.
- Embedding reflective practice, supervision, and consultation within delivery models is essential, supporting practitioner learning, emotional processing, and the translation of training into sustained practice.
- Activity-based and non-traditional engagement strategies are effective for hard-to-reach groups by providing accessible entry points for participation and supporting relationship-building outside formal settings.
- Online and remote delivery improves accessibility but may compromise depth of engagement, particularly for relational and reflective components that rely on interpersonal connection and interaction.
- Delivery intensity and burden must be carefully managed as high emotional demands, lengthy training, and competing organisational pressures can reduce engagement and threaten sustainability.

- Delivery settings act as active enablers or constraints on implementation with organisational culture, leadership, and capacity strongly influencing whether TI approaches are embedded or remain superficial.
- Flexible, community-based, and psychologically safe environments enhance engagement, while rigid, procedural, or punitive institutional settings can limit relational practice and create tensions with TI principles.
- Sustained duration, repeated exposure, and continuity of support are essential for impact, but are frequently constrained by organisational timescales, workforce capacity, and competing demands, highlighting the need for longer-term and adequately resourced implementation models.

A comprehensive analysis of the findings across each domain is presented in the sections that follow.

Delivery method

Delivery method refers to the way in which an intervention's content is delivered and experienced in practice, including the structure, format, and techniques used to engage participants. It shapes how participants interact with programme content, how skills are developed, and the extent to which interventions are perceived as accessible, relevant, and engaging.

Across the 14 included studies (see Appendix 4), delivery methods ranged from highly flexible, relationship-based approaches embedded within routine practice to more structured training and workforce development programmes. Despite these differences, several themes emerged regarding delivery methods that facilitated and, in some cases, hindered engagement:

1. Relational and relationship-based delivery;
2. Flexible and individualised delivery approaches;
3. Interactive and practical learning approaches;
4. Reflective practice, consultation, and supervision;
5. Activity-based and practical engagement strategies;
6. Challenges associated with online and remote delivery;
7. Delivery burden, intensity, and sustainability.

1. Relational and relationship-based delivery as a facilitator of engagement

Across studies, relational and relationship-based approaches were identified as key facilitators of engagement in trauma-informed interventions. The evidence-base highlighted the importance of trust, consistency, collaboration, and personalised support in fostering participation and strengthening relationships with children, young people, and families.

Importance of relational delivery methods appeared as a prominent theme across studies. Interventions that prioritised trust-building, consistency, collaboration, and personalised support were consistently associated with stronger engagement. This was particularly evident in TI practice models implemented within youth justice, social care, and community settings.

Both the Enhanced Case Management (ECM) model²¹ and the Trauma Recovery Model (TRM) evaluated by Facer-Irwin²² were delivered through relationship-centred, TI approaches embedded within routine practice rather than through highly structured therapeutic programmes. Practitioners in both studies emphasised flexibility, trust-building, and adapting support to individual needs. Young people reported feeling listened to, respected, and involved in decision-making, while practitioners highlighted the value of spending additional time developing relationships before introducing more challenging intervention content.

Similar findings emerged from the Relationship Building Together (RBT) intervention¹⁴ where therapeutic alliance was identified as the primary mechanism underpinning engagement and behavioural change. Young people and families reported benefiting most from TI approaches when practitioners were approachable, consistent, and non-judgemental. Quantitative analyses further showed that weaker therapeutic alliances were associated with poorer behavioural outcomes, including higher levels of delinquency. Importantly, barriers emerged when delivery became inconsistent or procedural, such as through staff turnover, communication difficulties, or limited involvement of young people in decision-making. This highlights that the quality and consistency of relationships are critical to outcomes, with disruptions to relational delivery undermining effectiveness.

Relationship-based delivery was central within broader community and social care interventions. The Humber and North Yorkshire Trauma Informed Care Programme,²⁶ South East FfIC Vanguard Programmes,²⁷ and Fostering Connections²⁴ all emphasised relational safety, trust, and emotional support as core delivery principles. Across these studies, workers often provided support in ways that extended beyond formal intervention sessions, including practical assistance, advocacy, informal contact, and outreach work. Young people frequently described workers as trusted confidants or role models, while parents valued the non-hierarchical and supportive nature of interactions. In the South East FfIC programmes,²⁷ for example, youth workers engaged young people in community settings such as schools, cafés, and recreational venues, using persistent outreach and informal engagement. Using these methods, youth workers were able to build trust among those who were often reluctant to engage with statutory services. These findings demonstrate that flexible, relationship-based delivery extending beyond formal service boundaries plays a key role in engaging and supporting vulnerable populations.

2. Flexible and individualised delivery approaches

Across studies, flexible and individualised approaches were identified as key features of trauma-informed delivery, enabling support to be tailored to the needs and circumstances of children, young people, and families.

Flexibility and individualisation as core features of TI delivery were consistently evidenced across studies. Many TI programmes moved away from standardised or prescriptive delivery models in favour of adapting support according to participants' developmental readiness, needs, and circumstances. The ECM model²¹ demonstrated this whereby practitioners described using intervention sequencing to address immediate emotional, developmental, or practical difficulties before introducing offence-focused work. This sometimes involved delaying structured interventions while addressing housing instability, emotional dysregulation, bereavement, family difficulties, or mental health concerns. Practitioners believed this sequencing reduced conflict, strengthened relationships, and increased readiness to engage with subsequent intervention components.

Holistic and needs-led approaches extending beyond traditional intervention focus were also evident in several programmes. To illustrate this, the TRM²² encouraged practitioners to move beyond traditional compliance-focused approaches and work flexibly around young people's priorities. Staff described supporting young people with education, employment, housing, and daily living skills alongside more explicitly TI work. Within the Humber and North Yorkshire programme,²⁶ support was highly individualised and often combined therapeutic conversations with mentoring, advocacy, emotional regulation work, practical assistance, and participation in positive activities. Young people frequently highlighted activity-based sessions, community outings, sports programmes, cooking courses, and other practical opportunities as particularly engaging aspects of support.

Flexible, multi-level and family-oriented delivery models were further demonstrated in the South East FfIC programmes²⁷ which allowed children and families to access varying levels and combinations of support. The model allowed, for example, young people to receive mentoring support while parents or carers accessed parallel family or therapeutic interventions, supporting whole-family change. Stakeholders consistently viewed these adaptable approaches as more responsive and accessible than traditional services. However, while flexibility was generally regarded as a facilitator, some studies^{22,27} noted that highly individualised delivery could create challenges for consistency and sustainability. This was particularly the case where implementation relied heavily on practitioner expertise, discretion, and relational capacity.

3. Interactive and practical learning approaches

Across studies, interactive and practical learning approaches were identified as important facilitators of engagement. The evidence-base suggests that participants responded most positively to training that combined reflection, discussion, and real-world application of trauma-informed principles.

Interactive and experiential delivery as key drivers of engagement was evident across workforce development and school-based interventions. Specifically, engagement was strongest when delivery methods were reflective, participatory, and applied rather than didactic. Fostering Connections²⁴ provides one of the

clearest examples of this where participants repeatedly described experiential exercises, facilitated discussions, self-reflection activities, and collaborative learning opportunities as among the most valuable components of the programme. These approaches were perceived as helping participants translate abstract TI concepts into practical approaches relevant to social work practice. Many participants reported that the experiential style of delivery enhanced empathy, reflective capacity, and understanding of the lived experiences of children and young people in care.

Similar findings emerged from the Attachment Aware Schools Programme,¹⁷ More Good Days At School,⁴ Trauma Informed Schools UK,⁶ ACE Informed Schools,²⁰ and Carter's¹⁸ evaluation of TI professional development in an alternative high school. Across these studies, participants highlighted the importance of discussion-based learning, practical examples, opportunities to reflect on their own experiences, and activities that linked TI principles directly to classroom practice. School staff frequently reported that these approaches helped them reinterpret pupil behaviour through a TI lens and encouraged more reflective responses to challenging situations.

Grounding theory in real-world application across professional contexts was also a consistent feature of effective training. Richmond et al.²⁸ reported that participants valued case examples, videos, and visual materials that illustrated trauma concepts in realistic contexts. Similarly, officers participating in the Trauma Informed Policing Programme²³ valued training approaches that linked TI concepts directly to policing scenarios and operational decision making. Across sectors, participants consistently reported that learning was most engaging when theoretical concepts were grounded in realistic examples and practical application.

Limitations of overly theoretical or insufficiently applied training were identified in studies. Staff involved in Trauma Informed Schools UK⁶ and ACE Informed Schools²⁰ reported that some content lacked sufficient relevance to their day-to-day contexts, while participants in Richmond et al.²⁸ expressed a desire for more skills-based practice opportunities, including role-play and rehearsal of TI techniques.

1. Reflective practice, consultation, and supervision

Across studies, reflective practice, consultation, and supervision were identified as important components of trauma-informed implementation, supporting practitioner confidence, shared understanding, and the application of trauma-informed principles in practice.

Reflective spaces as integral components of engagement and implementation

emerged as a related theme, with multiple studies highlighting the importance of embedding reflective supervision, consultation, formulation meetings, and collaborative sense-making within intervention delivery. Reflective clinical supervision formed a central component of the TRM.²² Practitioners described supervision as providing opportunities to process emotionally demanding work, maintain TI perspectives, and develop more nuanced understandings of young people's behaviour. Staff in the TRM evaluation frequently described supervision as offering containment and emotional support analogous to the support practitioners aimed to provide for young people themselves.

Similar benefits were reported in the Trauma Informed Policing Programme,²³ where one-to-one reflective sessions, group discussions, and review of body-worn video footage enabled officers to critically reflect on communication styles, decision-making processes, and responses to incidents. Initial scepticism regarding reflective practice often diminished as officers experienced its practical value.

System-level reflective structures supporting shared understanding and collaborative problem-solving were central within the Lincolnshire Complex Needs Service²⁵ and Humber and North Yorkshire programme.²⁶ Staff reported that formulation clinics, consultation meetings, and communities of practice improved their understanding of complex cases, supported intervention planning, and facilitated shared learning across agencies. For instance, Bond-Taylor et al.²⁵ found 84.5% of staff reported that consultation helped them make sense of a

young person's behaviour, while 74.1% stated that it helped develop plans for working with young people and families. Reflective practice, therefore, appeared to strengthen practitioner confidence, support implementation fidelity, and facilitate the application of TI principles in complex real-world contexts.

2. Activity-based and practical engagement strategies

Across studies, activity-based and practical approaches were identified as important facilitators of engagement, providing accessible and less formal ways for children and young people to build relationships, develop confidence, and participate in support.

Activity-based and practical approaches as facilitators of engagement were highlighted across several interventions, particularly when working with children and young people who may struggle to engage through traditional verbal or formal environments. The Humber and North Yorkshire programme²⁶ incorporated a wide range of practical activities, including sports, gym sessions, cooking courses, community outings, digital workshops, and LEGO therapy. Young people frequently described these activities as central to their engagement, often emphasising that participation provided opportunities to leave the house, develop confidence, and build relationships in less formal environments. Staff similarly viewed practical activities as effective vehicles for relationship-building and emotional support.

Outreach and activity-based engagement within community and educational contexts was also central in the South East FfIC programmes²⁷ where youth workers met young people in community settings. Youth work was highly personalised, often using activity-based engagement to build trust and emotional safety, and focused on outcomes such as re-engagement with education, improved wellbeing, and increased participation in pro-social activities. Carter¹⁸ reported comparable findings within educational settings, where participants described benefits associated with mindfulness activities, journaling, creative expression, emotional check-ins, restorative conversations, and technology-enhanced learning. These approaches were viewed as increasing participation, supporting emotional expression, and creating more

accessible routes into discussions about wellbeing and trauma. These findings highlight that practical and activity-based approaches are particularly valuable for engaging participants who might otherwise struggle to engage with formal therapeutic or educational interventions.

3. Challenges associated with online and remote delivery

Across studies, online and remote delivery increased accessibility and participation, but was often perceived as less effective for fostering interaction, reflective discussion, and relationship-building than face-to-face approaches.

Online delivery improved accessibility but limiting depth of engagement. The clearest evidence emerged from Fostering Connections,²⁴ where participants described online reflective practice sessions as less immersive, less emotionally engaging, and more susceptible to workplace distractions than in-person sessions. The programme's e-learning modules and online Community of Practice were also viewed as being difficult to navigate and poorly integrated into wider programme activities.

Similar findings were reported in More Good Days at School,⁴ Trauma Informed Schools UK,⁶ and the Trauma Informed Policing Programme.²³ While participants valued the convenience of online delivery, they consistently reported reduced opportunities for interaction, reflective discussion, and relationship-building compared to face-to-face sessions. Although some programmes introduced shorter sessions, blended models, and breakout formats to address these issues, online delivery was generally perceived as less effective for interventions reliant on interpersonal and reflective engagement.

5. Delivery burden, intensity, and sustainability

Across studies, the intensity and sustainability of trauma-informed delivery were identified as important implementation challenges, with workload pressures, emotional demands, and competing organisational priorities sometimes limiting ongoing engagement and delivery.

Challenges associated with the intensity and sustainability of delivery models

were also demonstrated across studies. Participants often reported that lengthy training sessions, emotional demands, competing organisational priorities, and workforce pressures could undermine engagement and implementation.

Within school-based interventions, staff frequently highlighted challenges balancing training requirements alongside existing responsibilities. More Good Days At School,⁴ Trauma Informed Schools UK,⁶ ACE Informed Schools,²⁰ and Attachment Aware Schools¹⁷ all reported concerns regarding workload pressures, competing priorities, and difficulties sustaining implementation beyond initial training periods. Engagement was often strongest immediately following training but became more difficult to maintain without ongoing reinforcement and support.

Within relational interventions, concerns centred more on emotional demands. Practitioners delivering the TRM²² reported experiences of burnout, emotional exhaustion, and secondary traumatic stress associated with intensive relational work. Similar concerns were raised within the South East FfIC programmes,²⁷ where stakeholders questioned whether highly personalised and relationship-based approaches could be sustained as demand increased and caseload complexity intensified.

Delivery setting

Delivery setting refers to the organisational and environmental context in which an intervention is delivered, including the physical location, service system, organisational culture, leadership, workforce structures, and wider inter-agency environment. These contextual features can shape implementation processes, participant engagement, fidelity, and sustainability. This section focuses on evidence from primary studies regarding how characteristics of delivery settings facilitated or hindered implementation, rather than describing the settings themselves or examining setting-level differences in effectiveness.

Across the 14 included studies (see Appendix 4), delivery settings emerged as active influences on implementation rather than neutral contexts.

Four overarching themes were identified across studies:

- (1) Organisational culture and leadership;
- (2) Tensions between TI approaches and existing institutional structures;
- (3) The value of flexible and relational environments;
- (4) The importance of multi-agency integration.

The following sections of this report examine each of these themes in detail.

1. Organisational culture, leadership, and implementation capacity

Organisational culture, leadership, and implementation capacity were identified as key influences on the implementation of trauma-informed approaches. This was evident across a range of settings, where leadership engagement, organisational priorities, and workforce capacity shaped the extent to which trauma-informed principles could be embedded and sustained in practice.

Organisational culture and leadership as central determinants of implementation quality were consistently identified across intervention settings. Studies conducted in youth justice services, schools, local authorities, and multi-agency services all reported that TI approaches were more successfully embedded where leadership actively supported relational and developmental practice. For example, within the Enhanced Case Management (ECM) model²¹ implemented across Welsh Youth Offending Teams (YOTs), supportive management cultures enabled practitioners to spend additional time building relationships, sequence interventions flexibly, and respond proportionately to non-compliance. Conversely, implementation was more difficult where managers had not received training or where organisational pressures constrained flexibility.²¹

Leadership alignment within school systems shaping implementation and sustainability was similarly evident across school-based interventions, including the Attachment Aware Schools,¹⁷ More Good Days at School,⁴ Trauma Informed Schools UK,⁶ and ACE Informed Schools,²⁰ all of which highlighted leadership commitment and alignment with school priorities as critical to implementation. Schools with supportive leadership, strong wellbeing infrastructures, and relational cultures were better able to embed TI approaches across policies and practice. However, implementation was weaker in settings with competing

priorities or limited leadership engagement. Sparling et al.²⁰ further emphasised the impact of wider system pressures including Ofsted demands, staffing changes, and shifting priorities on sustainability, while Herrera et al.⁶ noted that organisational culture influenced whether TI approaches were embedded or treated as an additional initiative.

Organisational capacity and culture influencing implementation in social care and public services were also evident across broader systems. In the Fostering Connections programme,²⁴ implemented across eight local authorities, existing supervision structures, reflective practice arrangements, and organisational commitment to TI practice facilitated implementation. In contrast, workforce instability, high caseloads, administrative burden, and inconsistent managerial engagement created barriers to embedding learning in routine practice. Several participants reported that the absence of a systematic training strategy across teams created “knowledge gaps” where trained staff struggled to apply TI approaches consistently because managers or colleagues had not participated in the programme. Similarly, implementation of Relationship Building Together (RBT)¹⁴ across multiple youth-facing services was influenced by organisational capacity, with workforce turnover, restructuring, and competing operational demands disrupting continuity of delivery and relational engagement. Richmond et al.²⁸ further highlighted how wider organisational cultures influenced implementation, with participants describing procedural environments in sectors such as child protection and criminal justice as sometimes reinforcing distress and limiting flexibility. Staff reported that management practices did not always adequately reflect TI principles, particularly in relation to staff wellbeing and burnout, emphasising the need for more compassionate organisational cultures. This highlights that organisational culture and capacity not only influence implementation quality but also shape the extent to which TI principles are sustained and modelled within systems.

2. Tensions between trauma-informed approaches and institutional structures

Tensions between TI principles and the core functions of some delivery settings were identified. This was most evident in youth justice and policing contexts, where participants frequently described conflicts between relational, TI approaches, and statutory enforcement responsibilities.

Balancing relational approaches with statutory and enforcement

responsibilities in youth justice was particularly evident within the Trauma Recovery Model (TRM),²² which was implemented in a Youth Justice Service in the East of England. Practitioners viewed youth justice settings as particularly appropriate environments for TI work given the high prevalence of adversity and complex trauma among justice-involved young people. However, staff also described tensions arising from enforcement responsibilities, including breach procedures for non-compliance, court reporting, and custodial processes. Participants described discomfort with balancing young people's vulnerability against risk management priorities and questioned whether TI care could be fully realised within systems that retained coercive or punitive functions. Similarly, findings from the Enhanced Case Management evaluation²¹ suggested that while TI approaches could be integrated into existing case management and assessment systems, practitioners operated within organisational contexts characterised by high workloads, procedural demands, and performance pressures, which constrained the prioritisation of relational and developmental work.

Operational demands often constrained TI practice in policing contexts. This was evident in the Trauma Informed Policing Programme,²³ where Trauma Informed Practitioners were embedded within operational policing teams. Although the police station environment facilitated observational learning, reflective discussion, and integration of TI thinking into routine policing practice, officers reported that operational priorities such as emergency response, arrests, safeguarding demands, and performance targets often took precedence. This limited the extent to which TI engagement could be consistently applied in day-to-day policing contexts. Participants further noted that officers were expected to practise in TI

ways within organisational systems that did not always adequately support staff wellbeing, reflective practice, or responses to vicarious trauma.

Tensions between trauma-informed approaches and disciplinary frameworks

in educational settings were also observed, although often less pronounced than in justice or policing contexts. Several evaluations reported challenges reconciling TI approaches with existing disciplinary frameworks, accountability requirements, or behaviour management systems.^{6,17,18} Across sectors, findings suggest that implementation was often constrained when core institutional priorities were perceived as inconsistent with relational and TI principles. In Fancourt and Sebba,¹⁷ for instance, participants in some settings described challenges balancing attachment-aware approaches with institutional expectations around discipline, fairness, and accountability. Similarly, Carter¹⁸ suggested that disciplinary structures and operational pressures within the alternative school setting sometimes conflicted with the flexibility and relational focus required for TI practice. These findings suggest that alignment between institutional frameworks and TI principles is critical for consistent and effective implementation across sectors.

3. Flexible, community-based, and psychologically safe environments

Flexible, community-based, and psychologically safe environments were identified as important facilitators of engagement across studies. This was particularly evident in interventions working directly with children and young people, where flexible delivery settings and non-clinical environments were perceived to support emotional safety, relationship-building, and participation.

Flexible and non-traditional delivery environments supporting engagement and relationship-building were highlighted across several studies, particularly within interventions working directly with vulnerable children and young people. The Humber and North Yorkshire Trauma Informed Care Programme²⁶ deliberately adopted a flexible approach, allowing young people to choose meeting locations including schools, cafés, community venues, outdoor settings, programme offices, and activity-based environments. Participants consistently reported that flexibility increased feelings of safety, reduced barriers to engagement, and supported the

development of trusting relationships. Formal office environments were sometimes perceived as intimidating, leading practitioners to adapt delivery settings according to individual needs and preferences.

Community-based and informal environments facilitating relational engagement were also central to the South East FfIC Community Vanguard Programmes²⁷ which delivered support across homes, schools, community venues, recreational settings, and clinical environments. Practitioners reported that familiar and non-clinical settings reduced anxiety and facilitated engagement, particularly among young people with histories of trauma or previous negative experiences with services. Youth workers frequently used informal community-based and activity-focused environments to support relationship development and participation.

Adaptation of physical environments to support emotional safety in educational settings was demonstrated in Carter's¹⁸ evaluation of a TI programme in an alternative high school. Staff created calming spaces, including "peace corners," sensory areas, and emotionally supportive classroom environments, which were perceived to strengthen trust, emotional regulation, and student-adult relationships.

External constraints limiting the maintenance of flexible relational environments were also identified, particularly in relation to the COVID-19 pandemic. Facer-Irwin²² highlighted how the pandemic constrained delivery settings, with remote working and reduced face-to-face contact undermining relationship-building. This also limited informal collaboration and weakened the sense of connectedness central to TI practice. Practitioners reported difficulties maintaining meaningful engagement through phone or video contact, alongside increased isolation within staff teams. These findings contrast with more flexible, in-person delivery models and illustrate how external constraints can significantly shape the feasibility of TI approaches.

4. Multi-agency integration and system-wide delivery settings

Multi-agency integration and system-wide delivery settings were identified as important influences on the implementation of trauma-informed approaches. This was particularly evident in interventions spanning multiple services and

sectors, where collaboration, shared practices, and coordinated working shaped the delivery and sustainability of trauma-informed support.

Multi-agency working as a facilitator of holistic and coordinated practice was generally viewed positively across studies. Many interventions were delivered within complex systems involving multiple agencies, and the quality of collaboration across these systems frequently affected implementation success. ECM²¹ practitioners reported that multidisciplinary case formulation meetings involving education, mental health, housing, and children's services strengthened implementation, although sustaining engagement from partner agencies became more difficult over time. Similarly, RBT¹⁴ practitioners identified collaboration across social care, education, psychology, and youth justice services as improving holistic understanding of young people's needs and enhancing coordinated support.

System-wide integration enabling broader organisational change was most evident in large-scale initiatives including the Humber and North Yorkshire Trauma Informed Care Programme,²⁶ the Lincolnshire Complex Needs Service,²⁵ and the South East FfIC Community Vanguard Programmes.²⁷ Across these initiatives, implementation extended across local authorities, health services, schools, social care, youth justice, policing, and voluntary sector organisations. Participants reported that shared language, improved communication, consultation structures, and integrated working arrangements facilitated the embedding of TI approaches across organisational boundaries. In some cases, this resulted in broader systems changes, including TI police training and the development of "custody passports" to ensure police officers were informed about children's needs before detention.²⁶ This highlights that effective cross-system integration can support not only implementation, but also wider transformation of practice and policy.

Challenges arising from fragmented systems and competing organisational priorities were also widely reported. Several studies reported fragmented systems, differing organisational priorities, inconsistent understandings of TI practice, and barriers related to information sharing and governance.^{22,26–28} Facer-Irwin²² further highlighted how youth justice practitioners experienced disjointed inter-agency working, with conflicting priorities across social care, education,

mental health, policing, and courts. This often resulted in inconsistent or potentially retraumatising responses for young people. Maintaining engagement from partner agencies was frequently difficult due to competing priorities and resource constraints. Participants in the South East FfIC Community Vanguard Programmes²⁷ suggested that co-located or shared hub spaces could strengthen integrated working.

Structural and policy-level factors shaping sustainability and implementation, were also identified as important influences. Financial pressures, austerity, staffing limitations, and uncertainty around long-term funding were viewed as major threats to sustainability, while broader criminal justice and policy contexts were often perceived as remaining predominantly punitive and insufficiently aligned with TI principles.²² This indicates that wider structural and policy contexts play a critical role in enabling or constraining the long-term sustainability of TI systems.

Duration/dosage

Duration and dosage refer to the length, frequency, intensity, and cumulative exposure associated with an intervention, including how long programmes are delivered, how often participants engage, and the extent to which support is sustained over time. This section focuses on evidence from primary studies regarding how characteristics of intervention duration and dosage facilitated or hindered implementation, rather than describing intervention dosage itself or examining dosage-related differences in effectiveness.

Across the 14 included studies (see Appendix 4), duration and dosage emerged as important influences on implementation quality rather than simply delivery characteristics.

Five overarching themes were identified across studies:

- (1) The perceived importance of sustained and relationally focused engagement;
- (2) Pressures between the time required for TI work and existing organisational or statutory timescales;
- (3) Challenges balancing intervention intensity with feasibility;

- (4) The value of repeated exposure and ongoing reinforcement;
- (5) Workforce capacity constraints affecting the ability to maintain adequate duration and continuity of support.

The following sections of this report examine each of these themes in detail.

1. The importance of sustained and relationally focused engagement

The importance of sustained and relationally focused engagement was identified across studies. This was particularly evident in interventions working with children and young people with complex needs, where trust-building, emotional safety, and relational consistency were viewed as requiring time, continuity, and ongoing support.

Sustained engagement as essential for TI change was a recurring finding, with studies consistently indicating that meaningful outcomes often required longer-term involvement, particularly for children and young people with complex trauma histories. Studies examining direct work with young people repeatedly highlighted that trust-building, emotional safety, and relational consistency developed gradually and were often incompatible with short-term intervention models. Evaluations of the Trauma Recovery Model (TRM) within youth justice services emphasised that young people frequently required prolonged periods of engagement before they were able to participate fully in offence-focused work or discuss traumatic experiences. In the ECM model,²¹ average involvement lasted approximately 315 days, and stakeholders viewed this duration as necessary for relationship-building, multidisciplinary formulation, and the gradual sequencing of interventions. Similarly, staff implementing the TRM²² described trust-building as a gradual, non-linear process that often extended beyond the timelines imposed by statutory orders or organisational performance targets. Practitioners highlighted that young people often required extended periods of relational consistency before they were able to discuss emotional difficulties, tolerate offence-focused work, or engage meaningfully with support services. Taken together, these findings indicate that rigid timelines may be misaligned with the relational processes required for effective TI intervention.

Flexible, open-ended models supporting deeper engagement were particularly evident in programmes without fixed time limits. The Humber and North Yorkshire Trauma Informed Care Programme²⁶ was widely valued for providing what practitioners described as the “luxury of time” to build rapport and work at the pace of the child or family. Young people and parents contrasted this favourably with previous services that ended before trust had been established. Similar findings emerged from the South East FfIC Community Vanguard Programmes,²⁷ where both the Thames Valley Link and Building Belonging programmes intentionally avoided predetermined intervention end points. Practitioners reported that engagement often required several weeks of outreach before meaningful participation occurred. They also noted that sustained involvement over several months enabled more effective support for children with complex needs.

Continuity and consistency of relational contact as key to intervention quality were further emphasised in the Relationship Building Together (RBT) model.¹⁴ Both quantitative and qualitative findings suggested that intervention quality depended not simply on the amount of contact provided, but on the continuity and consistency of relational engagement over time. Interruptions to planned support were reported to undermine trust and weaken key mechanisms of change. These findings suggest that sustained, consistent relational engagement is central to both the effectiveness and integrity of TI interventions.

2. Pressures between required duration and organisational timescales

Pressures between the time required for trauma-informed work and organisational timescales were reported across studies, particularly where service or implementation timelines constrained relationship-building and longer-term change.

Tensions between required engagement duration and system-imposed time constraints were widely reported, with many studies highlighting inconsistencies between the time needed for TI work and the limits of existing service structures. Within youth justice settings, practitioners consistently reported that statutory orders often ended before longer-term developmental change could be

achieved.^{21,25} Similarly, Facer-Irwin²² found that staff experienced pressure to complete assessments and interventions within prescribed timescales even when relational foundations had not yet been established. Participants argued that official timelines frequently failed to reflect the realities of TI practice.

Short implementation periods constraining whole-system change in organisational settings were also evident in broader programmes. Staff involved in the Trauma Informed Schools UK programme⁶ frequently viewed the six-to-seven-month active implementation period as insufficient for embedding meaningful cultural change across schools. This was particularly the case given the complexity of changing behaviour systems, staff practices, and organisational routines. Likewise, participants in the ACE Informed Schools programme²⁰ argued that whole-school TI transformation should be understood as a gradual long-term process rather than a short-term initiative. However, they also noted that insufficient follow-up support and unclear timelines can limit sustained implementation. This highlights that achieving meaningful and sustained system change requires longer-term investment beyond initial implementation phases.

3. Balancing intervention intensity and feasibility

Studies identified balancing intervention intensity and organisational feasibility as a recurring challenge. This was particularly evident in workforce development and school-based programmes, where competing demands, staffing pressures, and organisational constraints sometimes affected the delivery and uptake of intended intervention components

Challenges balancing programme intensity with organisational feasibility were evident across studies, with difficulties emerging when attempting to deliver intended levels of input within busy service environments. Several workforce development and training programmes achieved planned delivery but encountered difficulties maintaining participant exposure to the intended dosage. For example, the 12-month Fostering Connections programme²⁴ successfully delivered all planned training and reflective practice components. However, participants frequently described the seven full-day training sessions delivered at

weekly intervals as difficult to accommodate alongside demanding social work caseloads. Views on optimal dosage varied, with some participants preferring more dispersed delivery and others favouring more concentrated training schedules.

Variation in delivery dosage due to organisational pressures in school settings was also observed in the More Good Days at School programme.⁴ This was often attributed to scheduling pressures, competing priorities, and staff availability. For instance, Reflective Practice Consultation Groups were often delivered less frequently than intended, while long gaps between sessions reduced continuity and momentum. To improve feasibility, schools commonly shortened sessions, split training across multiple sittings, or provided recordings for later access.

Adaptations to delivery formats impacting exposure and engagement in implementation were similarly reported in the Trauma Informed Schools UK programme,⁶ where examinations, inspections, staff absence, and competing school priorities led to missed webinars, consultancy sessions, and reflective supervision opportunities. Schools frequently adapted delivery formats by shortening sessions or extending implementation timelines. These findings suggest that while adaptation can support feasibility, it may also lead to variation in exposure that has implications for implementation fidelity and outcomes.

4. The role of reinforcement, supervision, and repeated exposure

The role of reinforcement, supervision, and repeated exposure was highlighted across studies as an important factor in supporting the implementation and sustainability of trauma-informed approaches. This was particularly evident in workforce development and organisational change initiatives, where ongoing support and reflective opportunities were viewed as necessary for embedding trauma-informed principles into routine practice.

Limitations of one-off training and the need for ongoing reinforcement were consistently highlighted across organisational and workforce-focused interventions. Participants reported that single training events were insufficient to embed TI practice, with repeated exposure, reinforcement, and ongoing reflective support identified as critical to implementation quality. Richmond et al.²⁸ found that although participants valued a one-day Trauma Awareness Training

workshop, many viewed it as only an initial introduction and expressed a desire for further practical training, refresher learning, and supervision. Similar findings emerged from the Attachment Aware Schools Programme¹⁷ and Carter,¹⁸ where participants highlighted the value of sustained professional development opportunities. They also suggested that continued support beyond the initial training period would strengthen implementation and sustainability. In Carter,¹⁸ weekly coaching, reflective journaling, and repeated implementation were identified as key mechanisms for building confidence, motivation, and consistency in practice.

Ongoing reinforcement supporting gradual embedding in system-wide initiatives was particularly evident in broader change programmes. Within the Humber and North Yorkshire programme,²⁶ communities of practice, reflective supervision, organisational development activities, and repeated training opportunities were viewed as critical for maintaining implementation momentum over the two-year evaluation period. Staff reported that repeated exposure facilitated gradual embedding of TI principles into routine practice. However, some participants also expressed a desire for longer-term support following programme involvement. Specifically, parents and young people highlighted the loss of consistent emotional support after interventions ended, while practitioners emphasised the need to balance ongoing support with maintaining professional boundaries.

Likewise, the Trauma Informed Policing Programme²³ demonstrated how ongoing engagement with Trauma Informed Practitioners, combined with supervision structures and repeated reflective opportunities, supported cultural change more effectively than standalone training alone. Officers reported that repeated interactions helped build trust and openness to reflective learning over time. This highlights that sustained relational and reflective support plays a key role in enabling deeper cultural change within organisations.

5. Workforce capacity as a constraint on duration and dosage

Workforce capacity was identified as an important factor influencing the duration and intensity of trauma-informed support across studies. Specifically, this is

evident in services working with children and young people with complex needs, where staffing pressures, increasing demand, and resource constraints often affected the continuity and sustainability of delivery.

Resource intensity and workforce capacity as key constraints on sustained delivery were consistently highlighted across studies, with substantial resource requirements identified as a major challenge for maintaining adequate duration and intensity of TI support. Across intervention types, workforce capacity emerged as one of the most significant barriers to maintaining adequate duration and dosage. High caseloads, workforce shortages, competing demands, and administrative pressures were repeatedly identified as factors limiting the intensity or continuity of support.^{14,23,25,26} In several studies, practitioners described prioritising immediate crises and risk management over longer-term relational work when resources were constrained. Similar capacity-related challenges were evident in school-based settings, where Carter¹⁸ found that staff struggled to balance trauma-informed social and emotional learning (TI SEL) delivery with academic demands, structured timetables, and behavioural pressures. Time constraints, student absenteeism, and short-term placements reduced cumulative exposure, while some students required gradual engagement due to initial resistance, further limiting intervention dosage.

Increasing demand challenging sustainability of flexible and open-ended models was particularly evident in programmes offering non-time-limited support. While the South East FfIC programmes²⁷ and Humber and North Yorkshire programme²⁷ demonstrated the benefits of non-time-limited engagement, both evaluations reported increasing demand that exceeded available capacity. Stakeholders expressed concerns about caseload growth, workforce sustainability, and the feasibility of maintaining highly personalised support without additional investment.

Emotional and organisational resource demands of sustained relational work were also highlighted in studies examining TI organisational change. Facer-Irwin²² found that staff viewed reflective supervision, manageable caseloads, and adequate staffing as essential for sustaining implementation quality, while concerns were raised that insufficient investment could result in diluted versions of TI practice. The ECM evaluation²¹ likewise highlighted the resource-intensive

nature of multidisciplinary formulation meetings and ongoing clinical consultation. Taken together, these findings indicate that sustaining TI practice requires not only financial and workforce resources, but also organisational investment in staff wellbeing and reflective support.

Experiences of children and young people

Findings relating to children and young people's experiences of TI approaches were drawn from two high quality studies, ^{4,14} four moderate quality studies, ^{6,22,24,27} and two low quality studies.^{17,26} Young people were not directly trained, but the impact of the programme was still evident in their experiences. Across the included studies, children and young people consistently identified trusting relationships, emotional safety, being listened to, and having support tailored to their individual needs as the most important aspects of TI interventions. Although the interventions varied considerably in setting and delivery, young people's accounts suggest that positive experiences were primarily driven by the quality of relationships with adults rather than by specific programme components.

A recurring finding across the evidence was the importance of adults understanding young people's personal histories, experiences of trauma, and cultural backgrounds. In the Fostering Connections evaluation,²⁴ young people emphasised that meaningful relationships depended on workers understanding their individual circumstances, with one participant explaining: "You just can't get along with someone that doesn't understand background and history, all of that." This highlights how relational trust was closely linked to practitioners' ability to recognise and respond to young people's lived experiences.

Similarly, evaluations across education, youth justice, and community-based services highlighted the central role of trusted relationships. In the Relationship Building Together intervention,¹⁴ young people described valuing practitioners who were consistently available and emotionally supportive. One participant reflected: "I think I just liked, like having someone to talk to and like that was there for me," while another highlighted the benefit of "being able to get out the house, even if it's just for an hour and just have someone there that you can talk to about

what you're worrying about." These relationships often contributed to increased emotional insight and coping skills, with one young person reporting: "It makes me feel like there is ways to cope... I've now got various ways of coping with things." Importantly, these changes were not always gradual but often occurred through significant moments of realisation or "lightbulb moments," where young people developed a clearer understanding of themselves and their circumstances.

The significance of relational practice was particularly evident in youth justice settings. Young people involved in the Trauma Recovery Model²² repeatedly contrasted TI relationships with previous experiences of statutory services, which were often experienced as punitive, impersonal, or judgmental. Some participants described past interactions that reinforced negative identities, with one recalling: "She used to tell me like, I'm a naughty boy. I'm not gonna – I'm not gonna be able to change or nothing." In contrast, participants valued practitioners who were authentic and emotionally available. As one young person explained: "[Practitioner] goes above and beyond... Where I would say me and [Practitioner] have a good friendship – we are very open and honest with each other." Another highlighted flexibility: "It was always – do you want to do this? ... he never said 'you have to do this.'" Trust was viewed as something that developed gradually through consistent and non-judgemental engagement. As one participant explained: "You've just got to have some time and leave them to have some time to understand you, really. You can't rush in." Another described how a practitioner shifted the perceived boundaries of the relationship, noting: "I wouldn't see him as a youth offending worker, I would see him as more of a friend." For some young people, these relationships were profoundly significant. One participant reflected: "[Practitioner name] is the first proper male figure that I've ever looked up to."

School-based interventions similarly demonstrated the importance of supportive adult relationships. Within the Trauma Informed Schools UK programme,⁶ pupils valued regular contact with trusted adults, describing these relationships as calming and reassuring. One pupil explained: "I just like having an adult I can really talk to in school... it's peaceful. Calm," while another stated: "Miss B is my trusted adult in the school... I just really like her." Pupils also reported that practical

tools helped them communicate emotions more effectively. Reflecting on the use of emotion cards, one pupil noted: "That helped me talk about my feelings and helped her understand me more." In some cases, this learning extended beyond individual use, with pupils recommending strategies to peers, for example: "You should do the cards with her – it helped me." This indicates a degree of normalisation of help-seeking behaviours within some school contexts.

Evidence from the More Good Days At School programme⁴ suggested that pupils experienced improvements in emotional support and staff responsiveness, even where they were unaware of the intervention itself. Young people described increased opportunities to discuss wellbeing and access support. One pupil explained: "If you tell like a normal teacher who's like not pastoral or anything, then they'll pass it on to pastoral." Others valued targeted wellbeing support, reporting: "It was very helpful for me because I felt comfortable talking with them, and they also helped me a lot. They gave me ideas to do when I'm stressed." Pupils also highlighted the value of dedicated wellbeing spaces, describing them as environments where "You feel really safe because you've got all the people that you need up there all the time" and "You'd get a timeout card, which you get 10 minutes out of a lesson to sort yourself out or go talk to someone." While it was not always clear whether these provisions were new or pre-existing, pupils' accounts suggested that they valued having places and mechanisms to support emotional regulation.

Across multiple interventions, young people reported that TI approaches improved how adults communicated with them. Pupils participating in school-based programmes described staff becoming more understanding, respectful, and collaborative. In More Good Days At School,⁴ one young person observed improvements in teaching approaches, noting that staff were "not shouting at students to stop and [speaking] in a good tone." Similarly, pupils involved in Trauma Informed Schools UK⁶ contrasted supportive interactions with previous experiences, with one pupil commenting: "Some teachers listen but don't hear it. Others actually talk to you like, 'How can I help with it?'" Another emphasised feeling respected: "She didn't speak down on me. She spoke with me."

Young people also valued flexibility and choice in how support was delivered. In the Humber and North Yorkshire Trauma Informed Care Programme,²⁶

participants described support as distinct from previous services because it adapted to their needs and preferences. One young person explained: "They ask you like what you can do, what days you can do, and what you want to do. Like they work in your way." The flexibility of support, combined with trusting relationships, appeared to facilitate engagement and emotional safety. As another participant stated: "She knows more what I'm going through than anyone else... I can trust her."

Many young people linked these relational experiences to perceived improvements in wellbeing, confidence, and behaviour. Participants across studies described feeling calmer, happier, and better able to manage difficult emotions. Young people in the Humber and North Yorkshire programme²⁶ reported learning strategies that helped them respond differently to challenging situations. One participant reflected: "I wouldn't just go yeah straight to a fight or hit someone, I would like, just like try and solve it." Similarly, young people involved in Relationship Building Together reported feeling more able to cope with difficulties and experiencing the intervention as "a very positive experience." In the Trauma Recovery Model evaluation,²² participants connected improved relationships with wider behavioural changes including reductions in offending behaviour and increased educational engagement. One young person reflected: "I used to get arrested all the time. I haven't been arrested in maybe like 6 or 7 months or something. I'm back in school as well" and another stated: "I've gone from drinking every day, and being involved with crime all the time, and getting in trouble with the police. To now, I don't do drugs, I barely drink, and I haven't had anything to do with the police in a whole year."

The availability of safe spaces and opportunities for emotional regulation emerged as another important aspect of positive experience. Pupils participating in Attachment Aware Schools¹⁷ and More Good Days At School⁴ described benefiting from spaces where they could calm down and access support when distressed. One pupil in the Attachment Aware Schools¹⁷ programme explained how a member of staff would remove them from class when they became upset: "She takes me out of class for a bit... She is a nice woman." Likewise, pupils in More Good Days At School⁴ described using wellbeing spaces and timeout arrangements that enabled them to "sort yourself out or go talk to someone."

Despite these positive experiences, some studies also identified challenges that negatively affected young people's engagement. In Relationship Building Together,¹⁴ disruptions to established relationships were particularly problematic. One participant noted: "I liked the first worker I had... but my second worker not as much," illustrating the importance of continuity, and how organisational changes such as council restructuring affecting staffing can disrupt relationships and weaken implementation. Poor communication also undermined experiences, with some young people reporting that they felt excluded from decisions or unable to express their views. One participant stated they were "not really allowed to speak," while another felt that workers "didn't come across as very kind people." In some cases, interventions were perceived as procedural rather than relational, with one young person commenting: "It's more like they were ticking boxes and less like they actually cared" while another stated, "In honesty, I wasn't really given much help." Feelings of limited agency were also evident, particularly where the intervention was experienced as compulsory rather than collaborative. As one young person explained, "it just felt very involuntary, and it did more harm than good." Such experiences highlight the importance of ensuring that young people are actively involved in decision-making processes and that support is framed as voluntary and responsive.

The ending of support was another area of concern across several interventions. Young people sometimes experienced the withdrawal of support as abrupt, particularly when strong relationships had developed. One participant in Relationship Building Together¹⁴ described the experience as: "you have all of this support and time and then... 'Goodbye' and they're gone." Additionally, the involvement of multiple agencies also shaped young people's experiences, sometimes in challenging ways. While multi-agency working aimed to provide comprehensive support, some young people experienced this as overwhelming or intrusive. For example, one described feeling that services were "ganging up" on them, while another reflected that such approaches could "drive a huge wedge between family members." This emphasises the importance of carefully planned endings and coordinated multi-agency delivery, ensuring that transitions are gradual, clearly communicated, and sensitive to relational dynamics to avoid unintended distress or disengagement.

Taken together, young people's experiences were shaped primarily by the quality and consistency of relationships rather than specific intervention models. While many reported positive impacts, these were easily disrupted by organisational factors such as staff changes, highlighting the importance of stable, relationship-focused implementation of TI practice.

How Much Does It Cost?

Four studies^{4,6,14,24} reported implementation cost data for TI Training and Service Redesign programmes delivered in the UK. Collectively, these studies provide evidence on the resources required to implement TI approaches across different organisational contexts, including local authority children's services, secondary schools, youth justice, and multi-agency provisions.

All studies were conducted between 2023 and 2026 and therefore reflect recent UK commissioning and service delivery conditions. Cost estimates were generated using contemporary workforce assumptions, salary structures, and implementation arrangements and are likely to be broadly relevant to current decision making in a context of continued financial pressure across children's services, education, and local government.

However, the findings should be interpreted with three considerations in mind.

First, cost estimates are reported using different units of analysis and therefore should not be compared directly.

- **Fostering Connections**²⁴ and **Relationship Building Together (RBT)**¹⁴ report costs per participating young person, reflecting direct intervention delivery.
- **More Good Days At School (MGDAS)**⁴ reports costs per school and per participating staff member, reflecting whole-school workforce implementation.
- **Trauma Informed Schools UK (TISUK)**⁶ reports costs per school and per pupil, with estimates varying depending on whether costs are distributed across a single year group or the wider school population.

Interventions delivered at an organisational level will typically generate lower per-pupil costs than intensive interventions delivered directly to individuals. Reported figures should therefore be interpreted as estimates of implementation resource requirements rather than comparative measures of cost-effectiveness.

Second, reported costs represent implementation expenditure rather than overall economic value. The studies describe the resources required to establish and deliver interventions but provide limited evidence on whether these investments lead to future savings, reduced service demand, or improved outcomes sufficient to offset costs.

Third, although the recency of the studies strengthens their relevance to current practice, it limits conclusions about sustainability and longer-term value for money. Most evaluations captured costs during early implementation periods, offering little insight into the ongoing investment required to maintain trauma-informed approaches beyond the initial training and implementation phase.

The following sections present findings for each intervention individually before drawing together cross-study observations.

Fostering Connections

Baan et al.²⁴ estimated that delivering Fostering Connections across eight local authorities cost £602,022 for 327 participating young people, equivalent to £1,841 per participant. Of this total, £226 per participant related to set-up activities and £1,615 per participant related to recurring delivery costs. Most of the expenditure was incurred by the programme delivery organisations, NCB and Coram Leap (£451,006), while local authorities contributed £151,016, primarily through staff participation in training and implementation activities.

Set-up costs were relatively modest and consisted mainly of preparatory meetings, development of training and e-learning materials, Community of Practice preparation, workshop planning, and software costs. As these costs were largely fixed, the programme may benefit from some economies of scale if implemented more widely.

Recurring costs accounted for most expenditure and were driven primarily by the ten-day social worker training programme. Costs included staff preparation and

delivery time, venue hire, travel, accommodation, catering, and associated support activities. Additional expenditure related to Trauma-Informed Champion activities, workshops, learning events, and ongoing implementation support. Local authority costs were largely limited to staff time for Supervising Social Workers, Young People's Social Workers, and senior leaders participating in programme activities.

The cost profile suggests a training-intensive intervention, with a relatively low direct financial burden on participating local authorities compared with overall programme cost. However, maintaining implementation quality and fidelity would require ongoing investment in workforce development and support. The analysis also excluded several potentially relevant costs, including routine social work activities, online infrastructure, and variation in engagement with implementation support activities, meaning that actual resource requirements may be somewhat higher than reported.

More Good Days At School (MGDAS)

Stepanous et al.⁴ estimated that implementation of MGDAS across 31 schools cost £2,172,731. Given the whole-school nature of the intervention, costs were reported as £70,090 per school and approximately £584 per participating staff member, based on around 3,720 staff participants. These figures should not be compared directly with the per-young-person costs reported for Fostering Connections or RBT, as they reflect organisational-level implementation rather than individual intervention delivery.

Set-up costs were modest, totalling £38,788 across all schools (approximately £10 per staff participant). These costs covered initial equipment, materials, and administrative activities. The overwhelming majority of expenditure (£2,133,943) related to recurring implementation costs.

Recurring costs were driven largely by workforce participation. Schools incurred costs associated with staff attendance at training, implementation coordination, and cover arrangements, while delivery team costs included staff delivery time, travel, and organisational overheads. Cost estimates assumed full programme compliance, with all staff attending seven hours of training, as well as additional

participation by senior leadership and pastoral staff in enhanced training sessions.

The findings indicate that whole-school trauma-informed transformation requires substantial organisational investment, particularly through staff participation and implementation activity. Although infrastructure costs were limited and schools were assumed to utilise existing facilities and administrative systems, the intervention required significant workforce capacity. Consequently, affordability and sustainability are likely to depend on schools' ability to absorb training and implementation demands within existing staffing and budgetary constraints.

Relationship Building Together (RBT)

Coulton et al.¹⁴ estimated that implementation of RBT cost £510,130 for 200 participating young people, equivalent to £2,551 per participant. This was the highest reported per-participant cost among the interventions reviewed, reflecting the intensive and individualised nature of the support provided. Total costs comprised £55,910 in set-up costs (£280 per participant) and £454,220 in recurring delivery costs (£2,271 per participant).

Unlike the predominantly training-focused interventions, RBT involved direct therapeutic and relationship-based work with young people and families. Consequently, ongoing delivery costs accounted for almost 90% of total expenditure. Set-up costs were driven entirely by workforce training, including standard practitioner training, enhanced trauma lead training, and enhanced case management training. These costs represented a one-off investment required to establish the intervention within participating services.

The vast majority of recurring expenditure related to staff time associated with assessment, preparation, intervention delivery, supervision, therapeutic support, and multi-agency collaboration. Preparation costs were relatively low, while intervention delivery costs were substantial, reflecting the involvement of multiple practitioners and the intensive nature of relationship-based work.

Costs varied considerably across service settings. The highest cost per participant was reported in Edge of Care services (£5,983), where support was typically more intensive and crisis focused. Lower costs were reported in Children's Services (£2,156) and Youth Development services (£2,178), while Early

Help (£2,264) and Youth Justice services (£3,285) fell between these extremes. This variation reflects the intervention's flexible and tiered design, with resource allocation adjusted according to level of need.

An important feature of the intervention was its reliance on existing organisational infrastructure. Costs were almost entirely workforce related. While this supports integration into existing service structures, it also means that sustainability depends heavily on practitioner capacity, supervision arrangements, and the availability of multi-agency support. Findings from the process evaluation suggested that workforce pressures, caseload demands, and staff turnover may present challenges to long-term implementation.

Trauma Informed Schools UK (TISUK)

Herrera et al.⁶ estimated that implementation of the TISUK programme cost approximately £32,566 per school. This comprised £14,087 in programme fees for training, consultancy, and materials, together with £18,479 in school staff time. Because the intervention was implemented across whole schools, costs were also reported on a pupil basis. When distributed across a typical school population of 1,000 pupils, implementation costs equated to approximately £33 per pupil. When calculated using only the targeted Year 8 cohort as the denominator, costs increased to approximately £196 per pupil.

These figures illustrate the importance of denominator choice when interpreting cost estimates for whole-school interventions. The intervention itself was not delivered solely to Year 8 pupils but sought to build capacity across the wider school workforce and organisational system. Consequently, costs can appear substantially lower when spread across all pupils who may potentially benefit from changes in school culture and practice.

The primary investment was workforce training and organisational capacity-building. Once trained, school staff were expected to apply trauma-informed approaches within their everyday practice, allowing future pupil cohorts to benefit without incurring equivalent external costs. This distinguishes TISUK from interventions requiring ongoing intensive service delivery.

However, the available data did not allow initial training costs to be separated from longer-term implementation activities, making it difficult to estimate

recurring costs. Furthermore, the costing excluded some potentially relevant expenditures, including administrative time associated with organising implementation activities and the purchase of additional resources such as sensory equipment.

From a commissioning perspective, the programme presents a potentially attractive capacity-building model characterised by relatively substantial upfront investment but potentially lower ongoing external costs. However, the extent to which this model represents good value for money depends on the degree to which schools successfully sustain and embed trauma-informed practices over time.

Cross-study observations

Several consistent themes emerge across the four studies.^{4,6,14,24} First, workforce costs were the dominant driver of expenditure regardless of intervention type. Training participation, supervision, intervention delivery, leadership involvement, and multi-agency collaboration consistently accounted for the majority of costs, while expenditure on buildings, equipment, and materials was relatively limited. This suggests that workforce capacity is likely to be the principal determinant of implementation feasibility across settings.

Second, the studies illustrate a continuum of resource intensity. Whole-school organisational change approaches such as TISUK⁶ and MGDAS⁴ involve substantial organisational investment but can distribute costs across large populations of staff and pupils. In contrast, Fostering Connections²⁴ combines workforce development with ongoing implementation support, resulting in moderate per-participant costs. RBT¹⁴ represents the most resource-intensive model, reflecting the costs associated with intensive, individualised support delivered directly to young people and families.

Third, several interventions demonstrated characteristics associated with scalability. Set-up costs were generally modest relative to recurring costs, and most programmes utilised existing organisational infrastructure. This suggests that expansion may be achievable without major capital investment. However, scalability does not necessarily imply sustainability. All four interventions depended heavily on workforce participation, organisational commitment,

supervision, and leadership support, meaning that long-term implementation remains vulnerable to staffing pressures and resource constraints.

Finally, none of the studies provided robust evidence regarding longer-term cost-effectiveness, sustainability, or return on investment. The available analyses focused primarily on the costs of implementation rather than whether those investments generate downstream savings through reductions in service use, placement instability, exclusions, offending behaviour, or other adverse outcomes. Similarly, evidence regarding the costs of maintaining trauma-informed approaches beyond the initial implementation period remains limited. Consequently, while the findings provide valuable evidence regarding affordability and resource requirements, conclusions regarding value for money should be interpreted cautiously. Further research is required to establish whether the substantial workforce investments associated with trauma-informed approaches translate into longer-term benefits and cost savings across education, social care, and youth justice systems.

Conclusion and Takeaway Messages

Evidence from this systematic review and meta-analysis indicates that TI Training and Service Redesign approaches produce a small reduction in violence among children and young people, alongside small improvements in outcomes for professionals. However, neither finding was statistically significant. There is no evidence of effect on children's overall outcomes.

Using robust techniques to pool the available evidence, these findings suggest that TI Training and Service Redesign approaches may contribute to targeted improvements in the specific domains of violence and professional outcomes. However, the effects were generally small and statistically non-significant.

There was insufficient data to conduct a separate meta-analysis of crime and offending outcomes. Only five crime and offending outcomes were identified, all from the same study, meaning that the evidence was too limited to support a reliable, pooled estimate.

There was minimal heterogeneity across effects, suggesting effects were broadly similar across outcomes, however, the low number of studies means that this

should be interpreted with caution. The low or absent heterogeneity, combined with the small number of studies, meant that subgroup analyses were not conducted. Therefore, it was not possible to determine whether effects differed according to study characteristics, intervention features, setting, population group, or outcome type. As a result, the meta-analysis cannot identify whether TI Training and Service Redesign may be more effective for particular groups of children and young people, in specific settings, or for specific outcomes beyond violence.

While TI approaches may be valuable as part of wider service improvement, the current evidence does not demonstrate an effect across children's overall outcomes.

Violence

TI Training and Service Redesign approaches were associated with a small, reduction in violence. The meta-analysis estimated a 6% relative reduction in violence, which is equivalent to an absolute risk reduction of 1 percentage point. In practical terms, this means that around 15% of children and young people receiving TI Training and Service Redesign were estimated to go on to be involved in violence, compared with 16% of those in comparison conditions. These findings are based on a meta-analysis of 22 violence outcomes across four studies.

The pooled effect showed a small reduction in violence, but it is important to note that it was not statistically significant ($p = .28$). Therefore, the possibility that the true average effect is zero cannot be ruled out. The overall evidence security rating is Level 3, indicating a moderate level of confidence in the evidence base, based on the number of studies rated as high quality.

The studies included in this meta-analysis provide some of the first causal evidence on the impact of TI Training and Service Redesign approaches on violence-related outcomes. While the findings suggest a small reduction in violence, it did not reach statistical significance, therefore the possibility of no true average effect cannot be ruled out. The current evidence is not strong enough to conclude that TI training and service redesign approaches, on their own, lead to a reduction in violence outcomes.

Taken together, the findings suggest that TI Training and Service Redesign may be able to contribute to violence prevention, but probably as part of a wider package of support, rather than as a standalone violence-reduction strategy. This is consistent with conclusions from a Home Office Report,⁷ as well as several studies included in this report,^{6,14,24} which emphasised that TI approaches are most likely to be effective when embedded within broader, multi-component systems of support, rather than delivered as isolated training or service-level activities.

The estimated absolute reduction is small, with approximately 1 percentage point between intervention and comparison groups. At an individual level, this is modest. However, if implemented across large systems, such as schools, youth justice services, children's social care, or community-based provision, even a small absolute reduction may have practical significance, particularly if delivered in a cost-efficient way.

All child outcomes

Beyond violence, a meta-analysis was conducted across all 124 identified YEF outcomes (4 studies, 12,738 children and young people). TI Training and Service Redesign demonstrated no evidence of impact on this broad spectrum of outcomes (SMD = -0.01, $p = .477$), securing a Level 3 evidence security rating.

The model estimated no residual heterogeneity, suggesting limited evidence that the effects varied beyond what would be expected from sampling error. This suggests that the lack of effect was relatively consistent across the outcomes examined.

Professional outcomes

A meta-analysis was conducted across all 22 professional outcomes from 4 studies. These outcomes measured trauma-informed attitudes, relationships, trust, emotional skills, staff wellbeing, and broader behavioural and health outcomes. The meta-analysis found a small benefit to professional outcomes across five studies. However, the pooled effect was small and statistically non-significant ($p = 0.341$), meaning that the possibility of no true average effect cannot be ruled out. Heterogeneity was low, suggesting the effects were relatively

consistent across the included professional outcomes. The overall evidence security rating is Level 3, indicating a moderate level of confidence in the available evidence.

In practical terms, this suggests that TI Training and Service Redesign approaches may result in some beneficial effects to professional practice or staff outcomes, but the current evidence is not strong enough to conclude that it has a reliable beneficial impact on professional outcomes across settings. As with the violence and all child outcomes, these findings should be interpreted cautiously given the small number of studies and the limited evidence base.

What works?

Evidence from fourteen studies suggests that TI Training and Service Redesign programmes are most successfully implemented when supported by strong leadership, organisational commitment, reflective supervision, and ongoing workforce development. High fidelity was most consistently achieved where TI principles were embedded within organisational systems and cultures rather than delivered as standalone training initiatives. Consistent with wider implementation literature, implementation quality appeared to depend on both workforce capability and organisational readiness, with workforce pressures, competing priorities, and limited capacity acting as common barriers.

Intervention quality was strengthened where staff received credible training alongside ongoing supervision, consultation, and opportunities for multidisciplinary learning. Across sectors, training was associated with increased understanding of trauma and greater confidence in relational practice. However, sustained implementation was more likely when training was reinforced through reflective practice, specialist support, and leadership engagement.

Reach and penetration were greatest where organisations adopted whole-system approaches. TI approaches were successfully embedded within participating teams and services, particularly where implementation was supported by collaborative working, relational practice, and ongoing supervision. However, wider system-level integration was often constrained by workforce

instability, fragmented interagency structures, and limited implementation capacity.

Relevance was enhanced through flexible, person-centred adaptations that responded to individual trauma histories, developmental needs, and barriers to engagement. While studies increasingly recognised the importance of cultural responsiveness, language needs, disability, and structural inequalities, relatively few reported systematic equity-focused adaptation frameworks.

Delivery methods that emphasised relationships, collaboration, participation, and reflection were consistently associated with stronger engagement. Interactive training, reflective supervision, and practical learning approaches appeared particularly valuable, while highly theoretical or less interactive delivery formats were generally perceived less positively. Similarly, implementation was facilitated by organisational cultures and delivery settings that supported psychologically safe, relational ways of working.

Duration and dosage were also important implementation considerations. Evidence suggests that TI change requires sustained investment, with ongoing coaching, supervision, consultation, and practice reinforcement supporting implementation quality. However, achieving intended levels of delivery was often shaped by workforce capacity, funding constraints, and wider organisational pressures.

The evidence base is particularly relevant to UK policy and practice, with thirteen of the fourteen studies conducted in UK settings. Although study quality was mixed, the consistency of findings across sectors provides a broadly coherent picture of the organisational and workforce conditions that support successful implementation of TI practice.

Who benefits most?

Findings were constrained by the lack of evidence on how experiences of TI Training and Service Redesign differed across demographic or personal characteristics. No studies explored age, education, care-experience, neurodiversity, intersectionality, or place of residence. Therefore, it is important

that future research explores equity-related variables in the context of TI approaches.

We planned and pre-specified subgroup analyses for gender, ethnicity, and socio-economic status (SES) at protocol stage. However, these analyses could not be conducted quantitatively because the evidence base did not provide extractable effects across at least two subgroup levels^d (and, in some cases, subgroup data were not reported at all). As a result, subgroup findings are presented narratively only.

Across subgroup analyses, there is no strong or consistent evidence that TI approaches benefit particular groups more than others based on gender, ethnicity, or socio-economic status. Most analyses found similar effects across groups, with no significant differences in overall outcomes.

There is some limited and inconsistent indication that effects may vary across specific outcome domains and subgroups. For example, some studies reported small positive effects for Black pupils on prosocial behaviour and peer relationships, and for more disadvantaged groups in certain outcomes, but these findings were not consistent and were often based on small samples. Overall, the evidence remains inconclusive, highlighting the need for further research to better understand which children and young people benefit most.

Limitations

Challenges with the studies measuring effectiveness

This review was limited by the small number of effectiveness studies available. Although the meta-analyses included a relatively large number of extracted outcomes, these were drawn from a small number of studies. This means that the evidence base remains small, and many outcomes were clustered within the same study. Although the estimated effects were consistently small or close to zero across the included studies, the limited evidence base means that these

^d At least two subgroup levels are required to estimate a between-group difference (i.e., to test whether effects differ across subgroups); with only one level, the subgroup comparison is not estimable.

findings should be interpreted cautiously. A further limitation is that we were unable to conduct subgroup or moderator analyses. This was due to the small number of studies, and the low or absent heterogeneity in effects. As a result, the meta-analysis cannot indicate whether TI Training and Service Redesign works better for particular groups of children and young people, in specific settings, with certain types of professionals, or when delivered in particular ways. We also cannot assess whether effects vary by intervention intensity, duration, setting, population characteristics, or outcome type.

A related limitation is the breadth of interventions grouped under TI Training and Service Redesign. Although the interventions shared an intention to embed TI principles through changes to professional practice, organisational processes or service delivery, they varied in their settings, populations, components, and delivery models. The pooled estimates therefore represent an average across related but diverse approaches, rather than the effect of a single, standardised approach. Given the small number of studies, it was not possible to examine whether effects differed between these approaches.

The low or absent detected heterogeneity should also be interpreted cautiously and should not be taken to indicate that the interventions or their effects were equivalent. On one hand, it suggests that the estimated effects were broadly similar across the included outcomes and studies, indicating available studies produced consistently small or null effects across the outcomes examined. However, the low heterogeneity may also reflect similarities in the evidence base. Four of the five effectiveness studies came from the same funder, the Youth Endowment Fund, and were conducted at similar times in UK settings under broadly similar service and policy systems. While this gives the evidence some relevance to UK policy and practice, it also means the review provides limited insight into how TI Training and Service Redesign might perform in more varied contexts, with different commissioning arrangements, delivery models, workforces, or populations.

A related consideration is the nature of the comparison services. During the study period (2023–2026), trauma-informed principles were increasingly embedded within routine UK service provision, supported by the Office for Health Improvement and Disparities (OHID) working definition of trauma-informed

practice and wider sector adoption. As a result, comparison services may already have incorporated trauma-informed elements, reducing distinctions between intervention and comparison services and potentially biasing effect estimates towards the null. These shared contextual features may have reduced variability between studies and contributed to the low heterogeneity observed in the analyses.

Additionally, due to the small number of included studies, we were unable to formally assess publication bias. While our searches were comprehensive and included grey literature, we cannot rule out the possibility that studies reporting non-significant or negative findings have not been identified or published. However, the pooled effect estimates observed in this review were already close to zero. As a result, even if unpublished studies exist, it is unclear whether their inclusion would materially alter the overall conclusions of the review. Nevertheless, publication bias remains a source of uncertainty and should be considered when interpreting the findings.

Challenges with the studies measuring implementation

Measuring the implementation of TI interventions presents several challenges. First, many core elements such as relational practice, therapeutic alliance, and cultural or organisational change are inherently complex, dynamic, and difficult to capture using standardised or quantitative measures. As a result, formal tools (e.g. checklists, attendance data, or adherence metrics) may fail to reflect the quality and depth of implementation, particularly where practice is embedded in everyday interactions rather than discrete activities.

Second, implementation often varies across settings, teams, and practitioners, making it difficult to assess consistency or compare outcomes. Adaptations to local context, workforce capacity, and participant needs can improve feasibility and engagement, but also introduce variability in delivery, dosage, and exposure, making it difficult to determine which elements of implementation are most critical for achieving consistent and effective outcomes.

Third, monitoring approaches are frequently inconsistent across programmes, with some relying heavily on informal or reflective methods (e.g. supervision, case discussions) rather than systematic data collection. While these approaches support learning and practice development, they can limit the comparability, reliability, and scalability of findings.

Fourth, there has been limited attention to equity within implementation measurement. Although some studies recognise the importance of cultural responsiveness and structural inequalities, few systematically assess how implementation varies across population groups or whether adaptations effectively address these differences.

Finally, broader organisational and system-level factors including workforce pressures, staff turnover, and competing priorities can affect both implementation and its measurement. These factors may not be fully captured in evaluation frameworks, yet they play a critical role in shaping how interventions are delivered and sustained. Together, these challenges highlight the need for more robust, multidimensional, and equity-informed approaches to measuring implementation in TI Training and Service Redesign.

Final thoughts and recommendations

Overall, this review suggests that TI Training and Service Redesign may be a promising component of wider support for children and young people in reducing violence, but the current evidence does not support it as a standalone approach to reduce violence. The clearest indication of potential benefit was for violence-related outcomes, where the pooled effect was small and in the favourable direction. However, this effect was statistically non-significant, meaning that the possibility of no true average effect cannot be ruled out.

This possible benefit did not extend across children's outcomes more broadly. When all identified YEF outcomes were analysed together, the pooled effect was very close to zero, indicating no evidence of overall impact on children and young people's outcomes. Professional outcomes showed a possible small favourable effect, but this was also not statistically significant, meaning there is not yet clear evidence that TI Training and Service Redesign reliably improves professional outcomes.

The evidence suggests that TI Training and Service Redesign approaches are most effective when supported by strong leadership, reflective supervision, and relational, flexible delivery embedded within organisational systems. While they show promise across settings, implementation remains shaped by workforce capacity, system alignment, and organisational context. Further research is needed to assess long-term outcomes, cost-effectiveness, scalability and equitable delivery.

Based on our systematic review and meta-analysis, we make the following key recommendations:

- Implement TI Training and Service Redesign as part of wider violence prevention and service improvement, not as a standalone violence-reduction intervention. The evidence suggests possible promise, but not a statistically reliable impact.
- Where the main aim is to reduce violence, crime and offending, or related child outcomes, commissioners should prioritise interventions with clearer evidence of effectiveness over TI Training and Service Redesign.
- The available studies produced broadly similar findings, with effects generally small and statistically non-significant. This suggests that repeating similar evaluations of broadly defined TI Training and Service Redesign may be unlikely to substantially change the overall conclusion.
- Future research should focus on testing the specific conditions, mechanisms, and implementation supports that may influence effectiveness, to better understand when and how TI Training and Service Redesign can work.

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Studies included in the effectiveness section are marked with an asterisk (*), studies included in the implementation section are marked with a dagger (†), studies included in both effectiveness and implementation sections are marked with both an asterisk and a dagger (*†), and cost evaluation studies are marked with a double dagger (‡) at the beginning of the reference.

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Appendix 1. Methods of the systematic review

Protocol

Prior to initiating this systematic review, we developed a comprehensive protocol for an Evidence and Gap Map (EGM) outlining the research objectives, eligibility criteria, search strategy, data extraction, quality appraisal, and synthesis methods. This protocol was registered and is available on the Open Science Framework (OSF),^e ensuring transparency and adherence to predefined methods.

Eligibility Criteria

To define the scope of relevant research, we applied the following criteria from the outset:

Table 6: Eligibility criteria for TI Training and Service Redesign studies

Eligibility criteria	Inclusion criteria	Exclusion criteria
Population	Children and young people aged 0–17. General population; Children and young people. The population for the interventions to support TI training and practice may include professionals and volunteers who work with CYP.	Studies with samples predominantly composed of adults aged 18 years and older. Where studies include wider age bands, data must be extractable for participants aged 0–17 (or the sample mean age must be ≤17 and the vast majority of participants under 18)
Intervention	Approaches implementing trauma-informed training and practice and should include:	Trauma specific interventions such as:

^e Protocol is available to access here: <https://osf.io/vamxy>

	1. Staff training and development 2. Changes to policies and ways of working that incorporate trauma, collaboration and information sharing within and across organisations, and support the development of safe, inclusive and positive environments 3. Implementing trauma-focused referrals and planning such as access to trauma-specific services and the incorporation of trauma history in case/service plans. Evaluations should explicitly state use of trauma-informed practice and/training	Trauma-focused Cognitive Behavioural Therapy (TF-CBT) Cognitive Processing Therapy (CPT) Various other psychotherapies, such as humanistic therapy, psychodynamic therapy and safety seeking therapy. Eye Movement Desensitisation and Reprocessing (EMDR) Studies that report on a specific service with the TIP framework but do not include wider organisational components.
Comparator	Children not intentionally exposed to trauma informed practice. Professionals not exposed to trauma informed training may be included.	clusters between two trauma-specific interventions.
Dose	Any	n/a
Setting	Interventions delivered in different settings including: the child welfare system (including children in care), schools, the justice system (including police), and the health system.	n/a

Activities	Activities that cover the 3 domains of TIP: Group or individual TrACE training sessions should be included. TrACE E-learning courses, in-person training, Changing the structures of an organisation to better accommodate individuals who have experienced TrACEs. TrACE consultancy services that help organisations to become more trauma informed.	Interventions that do not have the 3 core activities of trauma-informed practice
Participation	Universal to all CYP Targeted to those at risk, suffered ACEs, already offending	n/a
Who delivers the intervention	Any provider- typically organisations, trainers or consultants offering trauma-informed training to professionals who then implement trauma informed practice (Social workers, youth workers, doctors, nurses and other healthcare workers, schoolteachers, psychologists, therapists, counsellors, NHS Commissioners and safeguarding staff, community psychiatric nurses, religious and educational institutions, local government workers, independent sexual health advisers, police officers,	n/a

	addiction and homelessness practitioners, insurance claims handlers and prison officers.)	
Timing	Any	n/a
Study design	Randomised controlled trials (RCTs) and robust quasi-experimental designs (QEDs) e.g. those using difference-in-difference, synthetic controls, regression discontinuity, propensity score matching, or instrumental variables.	Studies without a credible counterfactual e.g. pre/post designs, QEDs with non-robust matching techniques

Details of searching

Prior to running academic database searches, the review team had already identified a number of potentially relevant studies from existing sources (n=2). These included studies coded within the EGM by the previous team, studies already included at the EGM stage by the current team, and references identified from previous reviews. In addition, a further set of records was identified through academic database searching and grey literature.

The academic search strategy was developed iteratively and refined through testing in MEDLINE. A set of pre-identified benchmark studies were identified by YEF at scoping stage, selected for their relevance to the review parameters and their coverage of key populations, interventions, and outcomes, was used to assess the sensitivity of the search. The strategy was refined until all benchmark studies were successfully retrieved, providing confidence that the search was capable of identifying relevant literature.

The final MEDLINE search strategy was subsequently adapted, with appropriate modifications to controlled vocabulary, syntax, and field codes, for use across additional databases and platforms.

Searches were conducted in the following sources:

- Ovid MEDLINE (EBSCOhost)
- Child Development & Adolescent Studies (EBSCOhost)
- Open Dissertations (EBSCOhost)
- Criminal Justice Abstracts (EBSCOhost)
- ERIC (ProQuest)
- APA PsycInfo (EBSCOhost)
- PsycArticles (EBSCOhost)
- Embase (EBSCOhost)

These databases were selected to ensure comprehensive coverage across psychology, education, criminal justice, health, and grey literature sources. The core conceptual structure of the search was retained across platforms, with database-specific adaptations applied to maximise sensitivity while maintaining relevance.

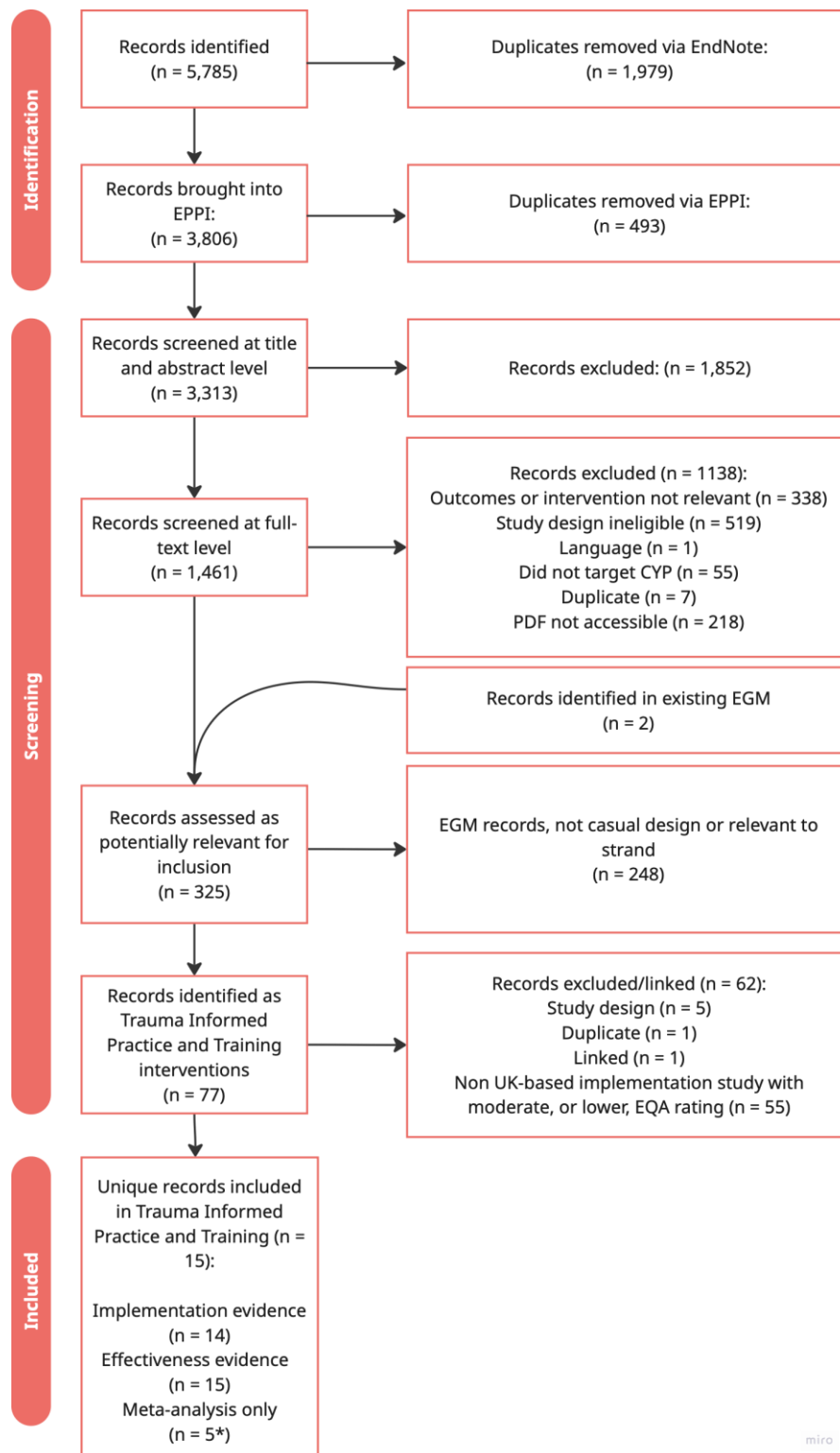
Details of screening

A total of 5785 records were identified as potentially relevant for the TIP strand (see Figure 8 for PRISM flow diagram). These records were first deduplicated in EndNote, leaving 3806 records to be imported into EPPI-Reviewer. Following further deduplication in EPPI-Reviewer, 3309 records from the database searches, together with 4 additional records provided directly from YEF, remained for title and abstract screening (n=3313).

The EPPI-Reviewer classifier conducted initial title and abstract screening. A total of 1,461 records were marked as included and 1,852 as excluded. As a quality assurance check, a random sample of 10% of records excluded by the classifier was reviewed by senior team members.

A team of reviewers then screened the full text for all included studies. Senior reviewers conducted a check of any exclusions, and any discrepancies were discussed as a team and reconciled.

Of the 1,461 records screened at full-text level, 1,138 were excluded (for reasons, see Table 22). For inaccessible PDFs, the team attempted to contact lead authors to request access to the report or further data.



*Of the 5 included studies, 1 included two multi-arm trials that contributed independent clusters for inclusion in the meta-analysis, resulting in 6 effectiveness study contributions overall

Figure 6: PRISMA Flow Diagram

Table 7: Full-text screening results

Reason for exclusion	Number of Records Excluded at Full-Text Level
Study design not meeting robust causal threshold	519
Outcomes or intervention not relevant	338
Did not target CYP	55
Language	1
Duplicate	7
Full text could not be retrieved (e.g., due to paywalls or removed repository entries)	218

Following full-text screening, 323 studies were flagged as potentially relevant for inclusion. An additional two records identified from the EGM were included, resulting in a total of 325 as potentially relevant for inclusion.

Table 8: Reasons for exclusion after full text screening

Reason for exclusion	Number of Records Excluded
Retained as EGM records but not causal or TI training and service redesign relevant	248
Study design	5
Duplicate	1
Multiple reports of same study	1
Non-UK-based implementation study with moderate, or lower, EQA rating	55

Initially the team identified 77 TI training and service redesign interventions which all went through our normal process for inclusion based on our scoping note. Following this assessment, 16 records were identified as fitting the scope for TI training and service redesign. This number reduced to 15 unique records as two records were multiple reports of the same study (Table 24).

Table 9: *List of linked studies*

Main study	Linked studies
Sparling (2022)	Sparling (2021)

Of the 15 unique study records, 14 studies provided implementation evidence, and 5 studies provided effectiveness evidence.

Therefore, this report includes **15 unique studies**:

- **14 studies** which provided implementation evidence,
- **15 studies** which provided effectiveness evidence in the broader review,
- 5 studies, including one multi-arm trial that contributed two clusters, provided usable quantitative data for the meta-analysis, resulting in **6 effectiveness study** contributions overall.

All exclusions made following full-text screening were reviewed by a senior reviewer to ensure consistency and accuracy.

Quality appraisal process for effectiveness studies

The YEF-EQA tool was used across all studies to systematically assess the quality, reliability, and relevance of the research. As four of the five included studies were evaluations funded by the Youth Endowment Fund, quality appraisal was conducted independently by two reviewers to reduce the risk of bias and provide an additional level of scrutiny.

Table 10: Quality appraisal ratings for studies included in the TI Training and Service Redesign strand

Study ID	Overall quality of the study	Study Design
Baan et al. (2026)	High	Cluster RCT
Coulton et al. (2026)	High	Individual RCT
Herrera et al. (2026)	High	Cluster RCT
Stepanous et al. (2026)	High	Cluster RCT
Whitaker et al. (2019)	Moderate	Cluster RCT

How the findings were analysed and combined

Preparing the data frame for analysis

Included studies comprised a mixture of individually randomised controlled trials, and cluster randomised controlled trials. For all studies, the primary effect size was the standardised mean difference (SMD) expressed as Hedges' g.

As is common in meta-analysis, the team encountered several challenges in harmonising effect sizes across studies. First, there was a need to standardise the direction of SMD values so that negative values consistently indicate a favourable intervention effect. To achieve alignment across all outcomes, we reviewed all effect size direction labels and, where necessary, multiplied positive SMD values by -1 for outcomes where a lower score signified improvement. This ensured that all SMDs reflected the same directional meaning, **that negative SMD values always indicate beneficial effects**. This approach supports clear interpretation and comparability across studies within the meta-analysis.

One outcome was an odds ratio and so were approximately converted into an equivalent SMD by multiplying the natural log of the OR $\times \frac{\sqrt{3}}{\pi}$ (approximately 0.5513).^f In practical terms:

$$SMD \text{ (Cohen's } d) \approx \frac{\sqrt{3}}{\pi} \ln(OR) = \frac{\ln(OR)}{1.814}$$

Additionally, 128 outcomes across five studies were from cluster randomised controlled trials. In a cluster trial, randomisation occurs at a group-level (e.g. school, classroom). People within the same cluster tend to be more similar to each other than to people in other clusters. There is therefore less information about the effectiveness of an intervention in a trial of 100 people in 10 schools than in a trial of 100 people randomised individually. This non-independence of participants within clusters must be accounted for or the effect size will be over-estimated. For cluster randomised trials which reported the effect sizes from cluster-adjusted analyses (e.g. mixed-effects models, generalised estimating equations) along with their standard errors or confidence intervals, we converted those estimates directly to Hedges' *g* and derived the standard error of *g* from the reported uncertainty, with no further adjustment required (*k*=37). However, for cluster randomised trials analysed as if they were individually randomised, the effect size precision was adjusted using a design effect (*k*=91).³³ The design effect (DE) was defined as:

$$DE = 1 + (M - 1)\rho$$

Where *M* is the average cluster size and ρ is the intracluster correlation coefficient (ICC). For these studies we retained the point estimate of *g* but inflated its standard error by *DE* (equivalently, we reduced the effective sample size in each arm by dividing the original sample size by DE before computing the sampling variance). When ICCs were not reported, we used values reported in the study, or similar studies in the same substantive area, matching outcome type and reporter (self-report, parent, or teacher) as closely as possible.³⁴ The impact of

^f Because this transformation is a linear scaling, the standard error of the SMD can be obtained by applying the same $\frac{\sqrt{3}}{\pi}$ factor to the standard error of the log OR

these assumptions was examined in sensitivity analyses by varying the ICC over a plausible range.

Meta-analysis

A random-effects model was fitted to the data. The amount of heterogeneity (i.e., τ^2), was estimated using the restricted maximum-likelihood estimator.³⁵ In addition to the estimate of τ^2 , the Q-test for heterogeneity³⁶ and the I^2 statistic³⁷ are reported. In case any amount of heterogeneity is detected, a prediction interval for the true outcomes is also provided.³⁸

Sensitivity analyses

Studentized residuals and Cook's distances are used to examine whether studies may be outliers and/or influential in the context of the model.³⁹ Studies with a studentized residual larger than the $100 \times (1 - 0.05 / (2 \times k))$ th percentile of a standard normal distribution are considered potential outliers (i.e., using a Bonferroni correction with two-sided $\alpha = 0.05$ for k studies included in the meta-analysis). Studies with a Cook's distance larger than the median plus six times the interquartile range of the Cook's distances are considered to be influential. The rank correlation test⁴⁰ and the regression test,⁴¹ using the standard error of the observed outcomes as predictor, are used to check for funnel plot asymmetry. The analysis was carried out using R (version 4.4.2)⁴² and the metafor package (version 4.8.0).⁴³

Implementation data

Information on factors that influenced, or were perceived to influence, implementation was extracted from studies where this was reported by study authors.

The data extraction for the toolkit extends the approach used in the EGM. Within the EGM, the focus was on whether implementation outcomes were measured, that is, whether studies reported indicators of how well a programme or intervention was implemented. In contrast, the toolkit data extraction focuses on explanatory factors, capturing why implementation did or did not proceed as

intended and what influenced these processes. These factors are typically conceptualised as barriers and facilitators to implementation.

In line with this approach, evidence on barriers and facilitators is organised into two overarching domains: (a) implementation processes and delivery capacity, and (b) delivery characteristics. Within these domains, findings are presented under the following categories:

Implementation processes and delivery capacity

- **Fidelity:** The extent to which interventions are delivered as intended, including the quality and consistency of implementation, barriers and facilitators to high-fidelity delivery, and any monitoring or feedback mechanisms.
- **Intervention providers and training:** The individuals responsible for delivering the intervention (e.g. teachers, school staff, external specialists) and the nature of their training and ongoing support. This includes consideration of how delivery may vary depending on provider characteristics and their experiences of implementation.
- **Reach and penetration:** Reach refers to the proportion and representativeness of the target population engaged, while penetration reflects the extent to which an intervention is embedded within services or systems. This includes evidence on participation, coverage, and integration into routine practice.
- **Adaptations for equity characteristics:** Any deliberate modifications made to ensure accessibility, acceptability, and effectiveness across different populations (e.g. adaptations related to ethnicity, disability, gender, or socio-economic deprivation), including how such adaptations influence engagement and, where reported, effectiveness.

Delivery characteristics

- **Delivery method:** The format and techniques used to deliver the intervention and engage participants, including factors influencing engagement across different delivery approaches.
- **Delivery setting:** The context in which the intervention is delivered (e.g. schools, community settings, online environments), including how setting

influences implementation quality and presents specific barriers or facilitators.

- **Duration/dosage:** The length, intensity, and frequency of delivery, including barriers and facilitators to achieving sufficient dosage and any implications for implementation quality.

All 14 studies included in this review contributed evidence across these domains. The implementation themes presented in this report were identified through a multi-stage narrative synthesis process. During data extraction, reviewers extracted information relevant to each predefined implementation domain from each included study. Findings were then compared across studies within domains to identify recurring facilitators, barriers, and implementation considerations. This process involved narrative synthesis of implementation findings rather than a formal thematic analysis. Consequently, the themes should be regarded as indicative patterns within the current evidence base rather than definitive determinants of successful implementation.

Given the large volume of available process evaluations, a prioritisation strategy was applied. UK-based studies were prioritised due to their relevance to the toolkit context. In addition, high-quality international studies, as assessed using the YEF-EQA tool, were included where they provided rich and complementary insights. This approach ensured that the synthesis drew on a focused body of evidence while maintaining analytical depth and contextual relevance.

Appendix 2. Location Details

	Number of UK Studies	Number (and Location) of International Independent clusters)
Contributing to Evidence Quality Rating	5	USA (N=1)
Contributing to Estimated Impact on Violence	4	0
Contributing to EDIE Data	2	0
Contributing to Implementation Data	13	USA (N=1)
Contributing to Cost Data	4	0

Appendix 3. Characteristics of included studies for meta-analysis

Authors (Year)	Country	Study Design	TI Approaches	Population/ Place	Comparison	Outcomes Measured	Quality Level	Findings
Baan et al. (2026)	England	Cluster RCT	Fostering Connections: A trauma- informed programme for social workers and foster carers to improve relationships, communication, and understanding of trauma among young people in care.	Young people, aged between 10–17 years old, residing in foster care or supported lodgings	BAU	Violence Behavioural Difficulties Building and Maintaining Relationships General Mental Health Hoping Others Regulating and	High	No significant effects on young people's behavioural outcomes, placement stability, or missing episodes. No significant effects on foster carer or social worker trauma- informed attitudes. . .

						Managing Emotions Stable Provision of Care Services		
Coulton et al. (2026)	Wales	Individual RCT	Relationship Building Together (RBT): staff training, trauma screening, and tiered approach based on trauma exposure.	Children and young people aged 10 to 21 who were referred to Youth Justice, Early Help, Edge of Care, Children's Services and Youth development in Bridgend, Wales	Services as usual; no additional staff training.	Violence, Crime and offending, Regulating and managing emotions, Helping others (prosocial behaviours), Building and maintainin	High	No significant differences between intervention and control groups on delinquency or secondary outcomes, although most findings favoured the intervention group. Though for three outcomes, the control group saw more positive results (SDQ hyperactivity SDQ

						g relationship s (social- emotional skills), Behavioural difficulties, General mental health, Family relationship s and support, Family conflict, School engageme nt,		prosocial and SDQ externalising behaviour).
Herrera et al. (2026)	England	Cluster RCT	Trauma Informed Schools UK:	40 schools across England.	38 schools across Englandconti	Violence, behavioural difficulties,	High	Small positive but non- significant effect on externalising

			whole-school trauma informed training and practice, consultancy, supervision, and practitioner diploma training.	Training was provided for the whole school, but outcomes were only collected for children and young people in year 8. Additional targeted support was available for some children and young people with identified needs.	nuing their usual practice.	general mental health, Helping others (prosocial behaviours), school engagement		behaviour. Secondary outcomes showed small or no effects. f
Stepanous et al. (2026)	England	Cluster RCT	More Good Days At School: whole-	Students in Years 8 and 9	BAU	Violence	High	No significant effects on pupil outcomes,

			school trauma-informed training for secondary school staff.	(aged between 12 – 14 years old) attending one of 62 schools (31 intervention and 31 control) included in the evaluation.		Behavioural Difficulties Bullying General Mental Health Goals for the Future Helping Others School Engagement School Provision of Emotional Health Support Victim of Crime	staff attitudes, attendance, suspensions, or exclusions. Higher bullying victimisation reported in the intervention group, although this finding should be interpreted cautiously. ,
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Whitaker et al. (2019)	USA	Cluster RCT	Enhancing Trauma Awareness [ETA]: training to increase staff understanding of trauma and its impacts.	32 classrooms / 48 teachers and assistant teachers from preschool classrooms.	31 classrooms / 48 teachers control teachers from preschool classrooms who did not receive the intervention and continued BAU.	School environment (school climate) School provision of emotional health support	Moderate	No significant effects on student-teacher conflict, relational capacity, or relational trust.
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Appendix 4. Characteristics of included studies for implementation

Authors (Year)	Country	Study Design	TI Approach (Name and brief description)	Quality Level	Summary of Findings
Baan et al. (2026)	England	Cluster RCT and process evaluation	The Fostering Connections programme: aims to reduce behavioural and emotional problems for young people in foster care or supported lodgings. The programme looks to achieve this by improving communication and relationships between social workers, giving better support to foster carers and implementing TIP to increase	Moderate	Implementation process and delivery capacity • Fidelity: Core training sessions were delivered with high adherence to programme aims and content across all participating local authorities, although fidelity was reduced by attendance challenges, adaptations to session content, and inconsistent engagement with implementation support components. • Intervention providers and training: Delivery by a diverse and experienced external facilitation team was widely viewed as a strength of the programme, with facilitators' expertise,

			understanding of trauma within the adults supporting YP in care.		lived experience, and experiential delivery style contributing to high participant engagement and perceived training quality. • Reach and penetration: While the programme successfully reached all eight participating local authorities, penetration within services was more limited, with only 42% of allocated social workers achieving the required level of training attendance and low engagement with wider support components. • Adaptations for equity characteristics: Adaptations were primarily made in response to workforce and delivery challenges rather than equity considerations, although stakeholders identified a need for greater attention to cultural responsiveness,
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					racial trauma, and the needs of diverse linguistic and cultural groups. Delivery characteristics • Delivery method: The experiential, interactive, and reflective delivery approach was consistently identified as a major strength, with participants viewing it as more engaging and impactful than traditional professional development approaches. • Delivery setting: Implementation was facilitated where existing supervision, reflective practice, and organisational support structures aligned with programme principles, but constrained by workforce instability, high caseloads, and inconsistent organisational engagement. • Duration/dosage: The intended programme dosage was delivered in full, but the intensity and scheduling of seven
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					full training days and reflective practice sessions created attendance challenges and were viewed by many participants as difficult to balance alongside existing workloads.
Bond-Taylor et al. (2025)	England	Process evaluation	Lincolnshire Children and Young People's (CYP) Complex Needs Service (CNS): trauma-informed, multi-agency service designed to support children and young people with highly complex and intersecting needs.	Very low	Implementation process and delivery capacity • Fidelity: The CNS was implemented largely as intended, with staff reporting high levels of satisfaction, relevance, usefulness, and impact of trauma-informed consultation and support, although implementation was sometimes constrained by crisis-driven work and caseload pressures. • Intervention providers and training: The service was delivered through a multidisciplinary model, with staff reporting high confidence in trauma-informed practice following training, consultation, and ongoing support from CNS professionals.

					• Reach and penetration: The CNS was well integrated across multiple services in Lincolnshire, supporting a large population of children and young people with complex and intersecting needs and achieving widespread uptake among Future4Me staff. • Adaptations for equity characteristics: The service adapted approaches and evaluation tools to improve accessibility for children and young people with communication needs, trauma histories, and neurodevelopmental differences, including the use of visual supports and co-produced materials. Delivery characteristics • Delivery method: Reflective consultation, formulation, and practical trauma-informed tools were identified as key facilitators of engagement and
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					implementation, helping staff better understand and respond to complex needs. • Delivery setting: Multi-agency working facilitated collaboration and embedding of trauma-informed practice, although organisational pressures and service constraints sometimes limited implementation. • Duration/dosage: Time-limited interventions, case closures, and crisis-driven practice reduced opportunities for sustained implementation, although repeated engagement with CNS support contributed to longer-term changes in practice.
Carter (2024)	US	Process evaluation	Trauma-informed care (TIC) professional development programme: within a non-traditional	High	Implementation process and delivery capacity • Fidelity: Implementation was generally supported by training, coaching, and reflective activities, but consistency was affected by varying staff buy-in, resource

			alternative high school serving students with exceptionalities and behavioural challenges. The intervention combined an initial two-day interactive training with four weeks of coaching, implementation support, reflective journaling, and the delivery of trauma-sensitive social and emotional learning (SEL) lessons.		constraints, and student attendance issues. • Intervention providers and training: The intervention was delivered by teachers, counsellors, and support staff who reported that sustained training and coaching increased their confidence, knowledge, and use of trauma-informed practices. • Reach and penetration: The programme reached a wide range of staff and students with behavioural challenges and exceptionalities, although full integration across the school was limited by inconsistent participation and organisational barriers. • Adaptations for equity characteristics: Staff adapted delivery through flexible participation options, small-group support, visual and sensory
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					tools, and tailored emotional regulation strategies to meet diverse student needs. Delivery characteristics • Delivery method: Interactive training, coaching, SEL lessons, reflective journaling, mindfulness activities, restorative conversations, and technology-supported learning facilitated engagement with the intervention. • Delivery setting: The alternative school setting was viewed as highly relevant for trauma-informed practice, although factors such as behavioural challenges, safety concerns, and resource limitations influenced implementation. • Duration/dosage: The intervention included two days of training followed by four weeks of coaching and weekly SEL delivery, with time pressures and student
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					absences creating challenges for consistent exposure.
Cordis Bright (2017)	Wales	Process evaluation	Enhanced Case Management (ECM) approach: grounded in the Trauma Recovery Model (TRM) and aimed to improve outcomes for young people with complex psychosocial, developmental, and offending-related needs through trauma-informed, psychology-led practice.	Low	Implementation process and delivery capacity • Fidelity: ECM was implemented with generally strong fidelity, with consistent delivery of case formulation, trauma-informed assessment, intervention sequencing and review processes, but with some variation due to uneven training access, limited supervision uptake, and challenges recording relational work within existing systems. • Intervention providers and training: Delivered mainly by YOT practitioners with support from managers and FACTS clinicians; training was well received and reinforced trauma-informed, relational practice, but inconsistent attendance (especially among managers) affected confidence and consistency across staff.

					• Reach and penetration: 21 young people were recruited across three YOTs, reaching a highly complex and vulnerable cohort; penetration was strong among trained practitioners but weaker and declining across wider partner agencies, with recruitment below target and variation between sites. • Adaptations for equity characteristics: Interventions were tailored to individual trauma histories, developmental needs and cognitive functioning, including additional assessments, psychoeducation and adjusted communication, alongside expanded eligibility criteria to improve access for vulnerable young people. Delivery characteristics • Delivery method: Delivered through a relational, trauma-informed model using multidisciplinary case formulation,
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					clinical consultation and flexible sequencing of support, prioritising relationship-building and underlying needs over offence-focused work. • Delivery setting: Implemented within YOTs operating in high-pressure statutory contexts, with delivery shaped by organisational demands and dependent on supportive management and sustained multi-agency engagement. • Duration/dosage: Average engagement was around 315 days (6–18 month orders), allowing time for formulation and relationship-building, but constrained by variation in order length and coordination demands across agencies.
Coulton et al. (2026)	Wales	Individual RCT and	Relationship Building Together (RBT): a model of practice which involves	High	Implementation processes and delivery capacity

		process evaluation	training for staff and trauma screening for young people. Young people are assigned a tier based on the level of trauma they experienced, and this tier determines the intensity of their treatment.		• Fidelity: Fidelity was influenced by both adherence to procedural components and the consistent application of trauma-informed, relational principles, with workforce instability, communication challenges and practitioner adaptations contributing to variability in implementation quality. • Intervention providers and training: Training, multi-agency collaboration and access to clinical psychologist support facilitated implementation, although staff varied in their understanding of the model's distinctiveness and reported challenges associated with the emotional demands of trauma-informed practice. • Reach and penetration: The intervention achieved broad implementation across multiple youth-facing services, but engagement depended on effective referral processes, accurate targeting
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					and continuity of practitioner relationships. • Adaptations for equity characteristics: While no formal equity-focused adaptations were reported, practitioners frequently adapted delivery to individual needs through flexible, person-centred approaches, although some participants felt key contextual issues remained insufficiently addressed. Delivery characteristics • Delivery method: The intervention's relational and trauma-informed delivery approach was central to engagement and perceived benefit, with strong therapeutic alliances facilitating positive outcomes and inconsistent or procedural delivery undermining participation. • Delivery setting: Multi-agency settings supported holistic care and collaboration, but organisational
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					pressures, restructuring and workforce instability created barriers to consistent and high-quality delivery. • Duration/dosage: Adequate dosage depended on sustained and consistent practitioner contact, but high caseloads and service pressures often disrupted delivery and reduced continuity of support
Elvin et al. (2025)	England	Process evaluation	The South East FfIC (Community) Vanguard Programmes: integrated, trauma-informed support for children and young people in complex situations across multiple service systems. The programmes combined strategic system development with direct	Moderate	Implementation processes and delivery capacity • Fidelity: Both programmes demonstrated strong fidelity to trauma-informed, relational and formulation-led practice, with consistent alignment to FfIC principles; however, Thames Valley showed more stable embedding over time, while Building Belonging experienced greater fidelity risks linked to rapid mobilisation, changing eligibility

			clinical and youth work interventions.		criteria, and system integration challenges. • Intervention providers and training: Across both programmes, delivery relied on multidisciplinary teams combining clinical, youth work and voluntary sector expertise. Thames Valley had more established workforce development structures (reflective practice, structured training pathways and AMBIT/complexity training), while Building Belonging delivered valued but more limited training and faced greater challenges in workforce consistency, clinical capacity, and equitable professional development opportunities. • Reach and penetration: Thames Valley achieved higher and more sustained reach (780 referrals, 97% accepted), with strong system-wide penetration across CAMHS, education, youth justice and social care. Building Belonging reached
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					fewer children and young people (72 referrals, 67 supported) and showed strong engagement with high-risk cohorts, but with more variable awareness, inconsistent referral flow, and greater dependence on single access pathways (C-SPA). • Adaptations for equity characteristics: Both programmes adapted delivery to individual need, including trauma history, gender matching, neurodiversity and family context, and used flexible, community-based engagement. Thames Valley demonstrated more structured and iterative system-level adaptations (e.g., staged rollout learning, co-production infrastructure), while Building Belonging made more reactive adaptations (eligibility changes, system workarounds, reduced budgets affecting activity-based equity offers).
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					Delivery characteristics • Delivery method: Both programmes used flexible, relational, stepped models combining direct work, consultation and multi-agency coordination. Thames Valley had a more embedded and coordinated delivery culture with consistent formulation-led practice and integrated youth work/clinical delivery, whereas Building Belonging delivered similar relational support but with greater variability due to staffing constraints and partnership complexity. • Delivery setting: Delivery in both programmes occurred across homes, schools and community settings, with strong emphasis on accessibility and non-clinical environments. Thames Valley additionally benefited from more embedded system integration and coordinated multi-agency settings, while Building Belonging faced challenges
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					linked to lack of shared physical infrastructure and reliance on statutory referral systems and single access points. • Duration/dosage: Both programmes offered flexible, non-time-limited support aligned to need, supporting engagement with highly complex cases. Thames Valley demonstrated longer average engagement (around 7–8 months) with structured caseload management, while Building Belonging also provided flexible durations but faced greater sustainability concerns due to part-time staffing, capacity constraints and open-ended demand.
Facer-Irwin (2022)	England	Process evaluation	Trauma Recovery Model (TRM): a trauma-informed care (TIC) initiative introduced within a Youth Justice	Moderate	Implementation processes and delivery capacity • Fidelity: Generally high relational fidelity, with practice aligning closely to trauma-informed principles centred on trust,

			Service (YJS) in the East of England. Rather than operating as a discrete therapeutic programme, the TRM represented a service-wide trauma-informed approach designed to reshape organisational culture, practitioner relationships, and responses to justice-involved young people.		consistency, and relationship-building rather than offence-focused delivery. • Intervention providers and training: Delivered by youth justice practitioners supported by TRM training and, in the pilot phase, clinical psychology supervision that strengthened trauma-informed reflective practice. • Reach and penetration: Broadly implemented across statutory youth justice caseloads, though depth of penetration varied due to competing service demands, resource constraints, and system pressures. • Adaptations for equity characteristics: Flexible, case-by-case adaptations were made to respond to trauma histories, family instability, safeguarding needs, and contextual
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					deprivation, enabling more individualised support. Delivery characteristics • Delivery method: Primarily relational one-to-one work, supplemented by family engagement and multi-agency collaboration, with emphasis on informal, responsive, youth-led interaction. • Delivery setting: Community-based delivery across homes, offices, schools, and remote/virtual contact during COVID-19, depending on accessibility and need. • Duration/dosage: Determined by statutory order length and case complexity, with impact linked more to sustained relational continuity than to structured session dosage
Fancourt and Sebba (2018)	England	Process evaluation	Attachment Aware Schools Programme: a	Low	Implementation processes and delivery capacity

			whole-school professional development intervention designed to improve school staff understanding of attachment theory, trauma, neglect, and emotion coaching to better support looked after children and other vulnerable pupils.		• Fidelity: High perceived fidelity overall, with strong-quality training and consistent improvements in staff understanding of attachment and emotion coaching, but variable implementation across schools due to differences in timing, follow-up, and limited formal monitoring or accountability structures. • Intervention providers and training: Delivered by external specialists and Virtual School staff alongside school-based staff, with training widely praised for quality and credibility; staff across roles reported increased confidence, but ongoing support and opportunities for sustained reflection were identified as important for consistent practice. • Reach and penetration: Broad reach across 24 schools and approximately 855 staff, with whole-school
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					engagement in many settings and some cascading to wider staff groups; however, deeper penetration was uneven, particularly where e-learning uptake and sustained engagement varied between schools. • Adaptations for equity characteristics: Schools made practical adaptations to support vulnerable pupils, including safe spaces, withdrawal areas, personalised emotional support, and relational approaches; while these improved responsiveness, tensions emerged around consistency and fairness in managing behaviour and interpreting needs. Delivery characteristics • Delivery method: Predominantly school-based CPD combining face-to-face training, discussion, and optional e-learning, enabling contextualised
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					learning and strong engagement, though with variability in follow-up, application, and opportunities for ongoing reflective practice. • Delivery setting: Implemented across diverse school contexts (primary, secondary, special, and alternative provision), with effectiveness shaped by leadership, school culture, and integration into pastoral systems; settings with stronger leadership engagement showed deeper embedding of practice. • Duration/dosage: Delivered across the academic year through multiple sessions plus optional e-learning, allowing sustained exposure but with uneven participation and timing across schools, which affected consistency and evaluation comparability.
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Herrera et al. (2026)	England	Cluster RCT and process evaluation	Trauma Informed Schools UK: involved whole-school trauma informed training and practice. Training was held for all staff and senior leaders, with consultancy and supervision also offered. Staff in some roles (e.g., SENCOs) completed diploma practitioner training. Children and young people viewed webinars to support their understanding of trauma and its impacts.	Moderate	Implementation processes and delivery capacity • Fidelity: Fidelity was mixed, with strong adherence to core training delivery by providers but inconsistent whole-school implementation in schools, largely shaped by leadership engagement, staff capacity, and contextual pressures, leading to variable embedding of trauma-informed practices. • Intervention providers and training: The programme was delivered by specialist Trauma Informed Schools UK trainers alongside school-based diploma trainees, with training and supervision generally well received and seen as credible and transformative, though implementation quality varied depending on staff role, engagement, leadership support, and staff turnover.
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					• Reach and penetration: Reach was broad at staff level across participating schools, but penetration into everyday systems and practices varied widely, with some schools achieving whole-school integration while others showed only isolated pockets of trauma-informed practice. • Adaptations for equity characteristics: Schools made local adaptations (e.g., tailoring materials for SEND/EAL pupils and adjusting delivery formats), but overall equity responsiveness was limited, with gaps in addressing racial trauma and inconsistent criteria for targeted support affecting inclusivity and fairness Delivery characteristics • Delivery method: Delivery combined whole-school training, leadership sessions, diploma training, consultancy,
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					and supervision, which was generally engaging and relational but sometimes experienced as time-intensive or insufficiently tailored, with adaptations (e.g., shorter sessions) affecting consistency. • Delivery setting: Implementation was strongly shaped by school context, with supportive leadership cultures enabling embedding into systems and routines, while competing priorities, existing behaviour regimes, and limited leadership buy-in constrained integration in other settings. • Duration/dosage: Although the programme ran over ~15 months, active implementation lasted only 6–7 months, with variable and often reduced dosage due to competing demands, staffing pressures, and scheduling constraints, limiting depth of whole-school change.
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Jacob et al. (2025)	England	Process evaluation	Humber and North Yorkshire Children and Young People's Trauma Informed Care Programme: aims to embed trauma informed approaches across organisations and services through training, communities of practice, organisational development tools, coproduction, and multi-agency collaboration.	Low	Implementation processes and delivery capacity • Fidelity: The programme was delivered broadly in line with a trauma-informed, relational model across sites, with core principles (relationship-based, child-led, flexible support) consistently evident, alongside some local variation in implementation. • Intervention providers and training: Delivery staff reported that trauma-informed and specialist training (e.g., ARC and exploitation-focused input) strengthened skills, increased confidence, and shifted practice towards more reflective, relational, and flexible ways of working. • Reach and penetration: The programme primarily reached high-need children and young people, including those at risk of exploitation, offending, or exclusion,
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					though access varied by referral pathways, awareness, and capacity across sites. • Adaptations for equity characteristics: Support was highly individualised and youth-led, adapting to young people's preferences, needs, and family contexts (e.g., location, activities, pace), improving engagement among those less likely to access traditional services. Delivery characteristics • Delivery method: Support was delivered mainly through relational, one-to-one work combining informal, activity-based engagement with reflective and sometimes therapeutic conversations focused on trust-building and emotional support. • Delivery setting: Sessions took place in flexible, negotiated settings including
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					homes, schools, community spaces, and public venues (e.g., cafés and outdoor spaces), chosen to maximise comfort and accessibility for young people. • Duration/dosage: There was no fixed programme length, with support duration and intensity tailored to need; this enabled sustained relationship-building but also created variability and, in some cases, demand exceeding capacity.
McCoy et al. (2026)	England	Process evaluation	Trauma Informed Policing Programme: aims to embed trauma informed approaches within frontline policing practice. The programme combined half-day trauma informed training sessions with the deployment of three	Moderate	Implementation processes and delivery capacity • Fidelity: The programme was delivered largely as intended, combining trauma informed training with ongoing TIP support, reflective practice, incident observations, body-worn video reviews, and safeguarding documentation feedback, supported by strong

			Trauma Informed Practitioners (TIPs) across five District Policing Teams.		supervision arrangements and quality assurance processes. • Intervention providers and training: Rock Pool delivered eleven half-day trauma informed training sessions and managed three independent Trauma Informed Practitioners (TIPs), whose expertise, supervision, and ongoing reflective support helped translate training into operational policing practice. • Reach and penetration: The programme trained 188 officers and staff and, between 2023–2025, TIPs attended or reviewed over 1,300 incidents, 49 PPN1 forms, 12 body-worn video recordings, 56 one-to-one reflective sessions, and multiple group discussions, although wider force-wide awareness remained more limited.
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					• Adaptations for equity characteristics: Training and TIP support encouraged officers to consider trauma, ACEs, racism, cultural differences, and wider social contexts, promoting more person-centred and less stigmatising approaches, though stakeholders identified scope for further development around racialised trauma and inclusion. Delivery characteristics • Delivery method: A blended model combined online training, incident attendance, reflective conversations, body-worn video and PPN1 reviews, wellbeing support, group discussions, and practical resources to embed trauma informed practice in day-to-day policing. • Delivery setting: Delivery was embedded within operational policing environments at Waterloo Police Station, enabling
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					real-time observation, feedback, and relationship-building, although implementation was affected by operational pressures, hierarchical structures, and competing demands. • Duration/dosage: Alongside initial training delivered over three months, officers received sustained support from TIPs through ongoing engagement, monthly peer supervision, one-to-one meetings, quarterly clinical supervision, regular site visits, and repeated reflective practice opportunities.
Richmond et al. (2022)	Scotland	Process evaluation	Trauma Awareness Training: designed to increase workforce awareness of trauma and support the implementation of trauma-informed practice across public	Low	Implementation processes and delivery capacity • Fidelity: The training was delivered consistently around core trauma-informed content (e.g., PTSD, complex PTSD, ACEs, trauma responses), with participants reporting improved understanding and confidence; however,

			services, in line with the NHS Education for Scotland “Transforming Psychological Trauma” framework.		implementation fidelity in practice was constrained by organisational pressures (e.g., time limits, rapid discharge systems) and a need for more experiential learning such as role-play and supervised practice. • Intervention providers and training: Delivered by experienced trainers to a multidisciplinary public sector workforce, with participants valuing real-life examples and applied explanations; ongoing supervision, reflective practice, and managerial support were identified as important for sustaining and embedding learning in practice. • Reach and penetration: The training reached a wide range of public sector workers across multiple agencies and was viewed as relevant across services; follow-up data suggested partial penetration into practice, with continued
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					use of psychoeducation (e.g., “window of tolerance,” “stress bucket”) and trauma-informed communication, though system-level barriers limited full integration. • Adaptations for equity characteristics: No formal adaptations were reported, but participants emphasised adapting communication, engagement, and assessment approaches for trauma-experienced individuals across contexts (e.g., child protection, vulnerable adults, young people), with increased sensitivity to triggers, non-verbal cues, and disengagement Delivery characteristics • Delivery method: A blended approach using presentations, videos, whiteboard explanations, and case examples supported engagement and
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					understanding; participants particularly valued real-life examples but requested more interactive methods (e.g., role-play and skills practice) to strengthen applied learning. • Delivery setting: Delivered across multiple public service settings (e.g., police, fire, housing, social services), with organisational culture and system constraints (e.g., workload, procedural demands, limited staff support) shaping the extent to which trauma-informed practice could be implemented. • Duration/dosage: A single one-day workshop produced increases in awareness, confidence, and knowledge, but participants consistently indicated that sustained change required additional training, refresher sessions, supervision, and ongoing organisational support.
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Sparling et al. (2022)	England	Process evaluation	Adverse Childhood Experiences-informed whole-school programme (ACE Informed Schools [AIS]): aims to embed trauma-informed and resilience-focused practices across school systems through staff training, organisational change, and the development of nurturing, relational approaches to behaviour and wellbeing.	Low	Implementation processes and delivery capacity • Fidelity: Implementation varied across schools; core AIS principles were adopted inconsistently and follow-up structures were often unclear. • Intervention providers and training: Educational psychologists and project staff delivered training, but staff found the content variably accessible and practical. • Reach and penetration: Initial rollout targeted schools judged ready and motivated, with limited evidence of system-wide embedding across the local authority. • Adaptations for equity characteristics: Schools were encouraged to adapt implementation to local needs, but
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					explicit adaptations for specific equity groups were not clearly reported. Delivery characteristics • Delivery method: Whole-school training, audits, action planning, and reflective relational practices were used, with engagement helped by collaboration but hindered when training felt overly theoretical. • Delivery setting: Leadership, existing inclusive/nurture culture, and wider local authority pressures strongly influenced implementation quality and sustainability. • Duration/dosage: The programme began with three training sessions, but participants reported insufficient ongoing support, unclear timescales, and difficulty sustaining implementation intensity.
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Stepanous et al. (2026)	England	Cluster RCT and process evaluation	More Good Days At School: aims to reduce externalising difficulties in secondary-school pupils by utilising TIP training for all school staff.	High	Implementation processes and delivery capacity • Fidelity: The MGDAS programme was delivered with generally high fidelity to core content across participating schools, although adaptations to session timing, format, attendance, and delivery intensity were common due to operational constraints and competing school priorities. • Intervention providers and training: Training delivered by programme implementers was viewed positively by staff and supported increased understanding of trauma-informed and relational approaches, with implementation quality enhanced by strong leadership engagement and staff participation. • Reach and penetration: The programme reached 25 secondary schools and was
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					most successfully embedded in schools with existing wellbeing infrastructures, although staff engagement and exposure to programme content varied considerably within schools. • Adaptations for equity characteristics: While no specific adaptations for demographic equity groups were reported, delivery was tailored through flexible scheduling, role-specific content, and contextualised examples to improve accessibility and relevance across diverse school settings. Delivery characteristics • Delivery method: Interactive, reflective, whole-school training methods facilitated engagement and promoted shared understanding of trauma-informed practice, although online delivery and lengthy sessions sometimes reduced participation and engagement.
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					• Delivery setting: Implementation was strongest in schools with supportive leadership, established wellbeing systems, and alignment between programme objectives and school priorities, while organisational pressures and staffing instability acted as barriers. • Duration/dosage: Most schools received the majority of planned programme components, but variation in session frequency, attendance, and continuity resulted from scheduling challenges and adaptations made to improve feasibility.
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Appendix 5. Characteristics of studies on cost and children and young people's views

Authors (Year)	Country	Study Design	Quality Level	Summary of Findings
Baan et al. (2026)	England	Cluster RCT and process evaluation	Moderate	Cost: Fostering Connections required substantial investment in training delivery (£1,841 per participant), with costs driven primarily by recurring training activities rather than programme set-up, suggesting a training-intensive but potentially scalable intervention. Experiences of children and young people: Young people did not directly discuss the training itself but emphasised the importance of social workers understanding their histories, identities, and experiences of trauma, indicating that the programme's focus on trauma-informed and relationship-based practice aligned closely with what they valued in supportive social work relationships.
Coulton et al. (2026)	Wales	Individual RCT and process evaluation	High	Cost: Total cost of £510,130 (£2,551 per participant), driven primarily by staff training and delivery time,

				with no additional infrastructure or material costs, indicating a resource-intensive but workforce-focused model Experiences of children and young people: Young people generally valued the intervention when relationships with practitioners were trusting, consistent and collaborative, reporting improvements in emotional regulation and wellbeing, while poor communication, limited involvement in decision-making and disruptions to support contributed to negative experiences.
Elvin et al. (2025)	England	Process evaluation	Moderate	Experiences of children and young people: Children and young people in both programmes generally reported feeling listened to, supported and better understood, particularly valuing consistent relationships with trusted workers. In Thames Valley, CYP described workers as persistent and stabilising, while in Building Belonging CYP emphasised being heard and emotionally supported, alongside improvements in safety, confidence and family relationships, though sample sizes for direct

				feedback from children and young people were limited in both evaluations.
Facer-Irwin (2022)	England	Process evaluation	Moderate	Experiences of children and young people: Young people reported increased trust, emotional safety, and openness with practitioners, often contrasting relationally supportive TRM experiences with prior punitive or transactional justice encounters
Fancourt and Sebba (2018)	England	Process evaluation	Low	Experiences of children and young people: Pupils experienced increased access to trusted adults, calmer responses to distress, and use of safe or withdrawal spaces for emotional regulation; support was typically embedded within wider pastoral systems, making impacts difficult to attribute solely to the programme, but pupils valued emotional support, reassurance, and consistent relationships.
Herrera et al. (2026)	England	Cluster RCT and process evaluation	Moderate	Cost: Approximately £32,566 per school (≈£33 per pupil whole-school), representing a largely one-off investment in training and staff time that builds

				internal capacity for ongoing delivery, with additional unquantified ongoing staff time and likely minimum estimated costs. Experiences of children and young people: Children and young people's perspectives were limited but suggested mixed experiences, with some benefit from improved relational support and emotional understanding, alongside potential risks of stigma or disengagement in targeted interventions depending on identification and delivery approaches.
Jacob et al. (2025)	England	Process evaluation	Low	Experiences of children and young people: Children and young people experienced the programme as supportive, flexible, and non-judgemental, valuing trusting relationships, improved wellbeing and confidence, and opportunities for positive activities, though some wanted longer or more ongoing support
Stepanous et al. (2026)	England	Cluster RCT and process evaluation	High	Cost: Total intervention cost was £2,172,731 across 31 schools (~£70,090 per school; £584 per staff

				participant), with schools covering £52,327 per school and the delivery team £17,764; set-up costs were £38,788 (~£10 per participant) and recurring costs £2,133,943 (~£574 per participant), mainly driven by staff training, coordination, and delivery time Experiences of children and young people: Pupils generally reported observing more supportive, relational, and understanding interactions from staff following implementation, suggesting that key elements of the trauma-informed approach were visible and meaningful from the pupil perspective.
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Appendix 6. Measured outcomes across included studies for effectiveness

YEF outcome framework category <i>Category description (as described in the framework)</i>	Measured outcomes <i>(descriptions by study authors)</i>	Studies
Violence	"SDQ_Conduct"; "volume of delinquency at month 6"; "Conduct"; "IBS Bullying Perpetration"; "SDQ Conduct Problems"	(n = 5, k = 22) Baan (2026)a; Baan (2026)b; Coulton (2026); Herrera (2026); Stepanous (2026)
Behavioural Difficulties	"SDQ_Conduct"; "Conduct"; "SDQ Conduct Problems"	(n = 5, k = 20) Baan (2026)a; Baan (2026)b; Coulton (2026); Herrera (2026); Stepanous (2026)
Building and Maintaining Relationships	"SDQ_Peer"; "Peer problems"; "SDQ Peer Problems"	(n = 5, k = 20) Baan (2026)a; Baan (2026)b; Coulton (2026);

		Herrera (2026); Stepanous (2026)
Bullying	"IBS Bullying Perpetration"	(n = 1, k = 1) Stepanous (2026)
Crime and Offending	"volume of delinquency at month 6"; "Police warnings"; "Police charges"; "Days in court"; "Days in custody"	(n = 1, k = 5) Coulton (2026)
Family Conflict	"Conflict"	(n = 1, k = 1) Coulton (2026)
Family relationship and support	"Cohesion"; "Expressiveness"	(n = 1, k = 2) Coulton (2026)
General mental health	"SDQ_Emotions"; "Regulation"; "GHQ12"; "SWEMWBS"; "Wellbeing (SWEMWBS)"; "Psychological distress (GHQ-12)"; "SDQ Emotional Problems"; "SDQ Impact Score"; "SDQ Emotional Symptoms"	(n = 5, k = 25) Baan (2026) ^a ; Baan (2026) ^b ; Coulton (2026); Herrera (2026); Stepanous (2026)
Goals for the Future	"SEI Future Aspirations and Goals"	(n = 1, k = 1)

		Stepanous (2026)
Helping Others	"SDQ prosocial subscale"; "SDQ_Prosocial"; "Prosocial"; "Pro-social behaviour"; "SDQ Prosocial Behaviour"	(n = 5, k = 13) Baan (2026)a; Baan (2026)b; Coulton (2026); Herrera (2026); Stepanous (2026)
Regulating and Managing Emotions	"SDQ_Hyper"; "Hyperactivity"; "SDQ Hyperactivity"; "SDQ Hyperactivity/Inattention"	(n = 5, k = 20) Baan (2026)a; Baan (2026)b; Coulton (2026); Herrera (2026); Stepanous (2026)
School Engagement	"Missed school days"; "School suspensions"; "School connectedness"; "Number of suspensions"; "Permanent exclusions"; "Authorised absences (sessions)"; "Unauthorised absences (sessions)"; "SEI Teacher-Student Relationships"; "Suspensions"; "Permanent School Exclusion"; "SEI Peer Support at School"; "SEI Control and Relevance of Schoolwork"; "School Attendance Percentage"	(n = 3, k = 13) Coulton (2026); Herrera (2026); Stepanous (2026)

School Environment (School Climate)	"decreased teacher-children conflict"; "Increased trust with parents"; "Increased trust with other staff"; "Increased trust with supervisors"; "Increased cognitive reappraisal"; "Decreased expressive suppression"; "Increased dispositional mindfulness"; "Increased perspective-taking"; "Increased empathic concern"; "Decreased personal distress"; "Increased compassion satisfaction"; "Decrease in any days poor health interferes"	(n = 1, k = 12) Whitaker (2019)
School Provision of Emotional Health Support	"ARTIC"; "ARTIC total score"; "ARTIC-35 Underlying Causes"; "ARTIC-35 Self Efficacy"; "ARTIC-35 Response to Problem Behaviour"; "ARTIC-35 Reactions to Work"; "ARTIC-35 Empathy and Control (on the job behaviour)"; "Increased ARTIC"	(n = 4, k = 8) Coulton (2026); Herrera (2026); Stepanous (2026); Whitaker (2019)
Stable Provision of Care Services	"Any unplanned moves (903 data)"; "Any missing from care episodes (903 data)"; "ARTIC underlying causes subscale"; "ARTIC scale"	(n = 1, k = 4) Baan (2026) ^a
Victim of Crime	"IBS Bullying Victimization"	(n = 1, k = 1) Stepanous (2026)

