BUILDING TRUSTED RELATIONSHIPS FOR VULNERABLE CHILDREN AND YOUNG PEOPLE WITH PUBLIC SERVICES

FEBRUARY 2018

Ben Lewing, Lara Doubell, Tom Beevers and Daniel Acquah

ACKNOWLEDGMENTS

This work has benefited from the valuable contributions and insights of Dr Anita Schrader-McMillan, Kirsten Asmussen, Steph Waddell and Clarissa White, and the guidance of Donna Molloy and Tom McBride.

We thank the Home Office for their funding and commitment in support of this research.

Any errors and omissions are the responsibility of the authors.

REPORT COMMISSIONED BY
THE HOME OFFICE

Home Office

Early Intervention Foundation
10 Salamanca Place
London SE1 7HB

W: www.EIF.org.uk
E: info@eif.org.uk
T: @TheEIFoundation
P: +44 (0)20 3542 2481

Contents

Summary

Introduction

Reviews of the child protection system have suggested that children who experience abuse lack a designated adult outside of the family system who is able to provide consistent support – or a 'trusted relationship'. The Home Office is interested in how to increase vulnerable children's access to trusted adults, and commissioned the Early Intervention Foundation (EIF) to review the evidence on which features of trusted relationships are critical to improving outcomes for vulnerable children and young people, and to provide policy advice on how more of these relationships could be enabled in public services.

The focus of this review was on early intervention with children and young people who are vulnerable to either child sexual exploitation (CSE) or child sexual abuse (CSA). The work included a rapid review of the published evidence-base and new, small-scale qualitative research with practitioners in this field.

Findings

1. There is a strong logic for thinking that trusted relationships between a practitioner and a child can protect vulnerable young people from CSE or CSA, but as yet no evidence to support this.
2. There is a lack of high-quality research evidence on the risk and protective factors for becoming a victim of CSE or CSA.
3. There is broad consensus between research and practice on the features which allow trusted practitioner–child relationships to develop.
4. The ability of public services to build trusted relationships with vulnerable children and young people appears to be influenced by the characteristics of the child or young person, the practitioner and the organisational context.
5. There is good evidence for the effectiveness of high-quality mentoring approaches.

Conclusions and recommendations

The conclusions of the report suggest that Home Office policy on trusted relationships should take a systems-focused approach, and should strengthen existing capacity and infrastructure rather than introducing new interventions with time-limited funding.

This systems approach should focus on:

- **System capability for trusted relationships**, including leadership at a national level on relational practice and systems, investment in local capacity for workforce planning and the development of relational practice and systems, and 'promising model' trials in demonstration sites.
- **Mentoring for vulnerable young people**, including the development of a consistent narrative about mentoring evidence, outcomes, quality and measurement to secure greater consistency and understanding, support for local development of mentoring quality, and 'promising model' trials in demonstration sites.
- **Effective implementation and evaluation**, including exploration of how best to change workforce behaviour and organisational culture on relational practice, and measurement and evaluation that adds to the UK evidence-base on relational practices, including use of key relational practice measurement tools.

1. Introduction

Previous research and reviews of the child protection system have both suggested that children who experience abuse lack a designated adult who is able to provide consistent support – or a 'trusted relationship'. The Early Intervention Foundation (EIF) was commissioned by the Home Office to carry out a rapid overview of the evidence as to which features of trusted relationships are critical to improving outcomes for vulnerable children and young people, and how more of these relationships might be enabled in existing public services.

The Home Office is particularly interested in how early practitioner–child trusted relationships can work to reduce the likelihood of vulnerable children and young people experiencing child sexual abuse (CSA) or exploitation (CSE). Although the impact of early trusted relationships would be expected to be observed in the child protection or criminal justice system, the locus of intervention is early intervention with children and young people who are vulnerable to either CSA or CSE.

EIF's research was designed around the following:

- A rapid strategic evidence overview, reviewing the evidence relating to practitioner–child trusted relationships, and identifying the strength of evidence for particular interventions.
- Consultation with practitioners and leaders from services working with children and young people, including local authority children's services and public health, the police, NHS and the voluntary sector.
- Testing and refining conclusions and recommendations with key stakeholders, including the Association of Directors of Children's Services, Local Government Association, NSPCC, Office of the Children's Commissioner and others.

This report is the culmination of EIF's work on trusted relationships, and is intended to draw together the key evidence and findings from that research, so that these are available to guide Home Office policy aimed at increasing the availability and impact of trusted relationships at a local level.

2. Key concepts and terminology

Child sexual abuse (CSA)

CSA involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware or not of what is happening. The activities may involve physical contact, including assault by penetration or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).[1]

Child sexual exploitation (CSE)

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where a child or young person (or a third person or persons) receives 'something' (such as food, accommodation, drugs, alcohol, cigarettes, affection, gifts or money) as a result of performing, and/or having another or others perform on them, sexual activities. Child exploitation can occur in posting sexual images on the internet or mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social, economic and/or emotional vulnerability.[2]

Vulnerability and prevention

The Munro Review of Child Protection[3] describes five levels of prevention (Department for Education, 2011: 79):

- Universal primary prevention: addressing the entire population and aiming to reduce the later incidence of problems.
- Selective primary prevention: fousing on groups which research has indicated are at higher risk of developing problems.
- Secondary prevention: aiming to respond quickly when problems arise in order to prevent them from getting worse.
- Tertiary help/prevention: responding when a problem has become serious, to prevent recurrence.
- Quarternary help/prevention: help after a serious problem has occurred to prevent or reduce long-term harm.

EIF's research focuses on early intervention for children and young people who are vulnerable to poor outcomes but have not experienced abuse or neglect. With

1 Based on the UK government's definition as set out in *Safeguarding Children and Young People from Sexual Exploitation* – available at: http://www.uknswp.org/wp-content/uploads/safeg.pdf

2 As above, based on the UK government's definition.

3 The Munro Review of Child Protection: Final report, 5.30, Levels of prevention

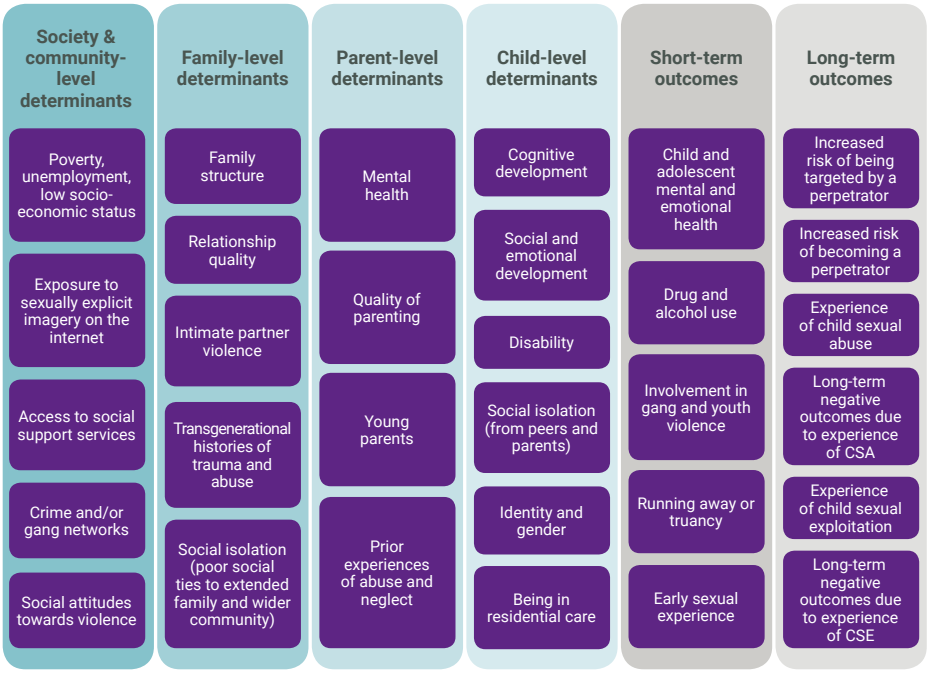
respect to the levels of prevention set out above, this means focusing on selective primary prevention and secondary prevention.

Children may be affected by an experience of CSA differently to an experience of CSE. Similarly, the risk factors for CSA may also be different to the risk factors for CSE. For the purposes of this report, however, while we recognise these differences between CSA and CSE, we do not consistently distinguish between CSA and CSE. We have instead focused on the presence of a trusted relationship as a preventative tool with the potential to reduce the risk of a child's vulnerability to both.

The ecological perspective

A helpful way to think about risk protective factors for child sexual abuse or exploitation is from an ecological perspective (Belsky, 1980; Bronfenbrenner, 1979). This allows us to organise risk factors into different categories: individual-level characteristics, family characteristics, contextual factors, and macro-system factors (Committee on Child Maltreatment Research, Policy, and Practice, 2014). These categories are presented in figure 2.1, outlining potential risk factors for experiencing CSA or CSE.

FIGURE 2.1: RISK FACTORS FOR CSA OR CSE: AN ECOLOGICAL PERSPECTIVE



Source: EIF

This conceptualisation recognises that risk and protective factors do not act in isolation. Rather, these factors are interrelated; interacting with each other in ways that may increase or decrease the overall risk of child sexual abuse or exploitation.

For example, families in or at risk of poverty (society-level) are at an increased risk of having a strained and poor-quality relationship (family-level). This in turn increases the risk of poor-quality parenting and poor parental mental health (parent-level). This could affect the social and emotional development of the child, as well as their mental health (child-level), which can in turn increase their risk of engaging in risky behaviours or situations (short-term outcomes) that can lead to an experience of child sexual abuse or exploitation (long-term outcomes).

Moreover, the presence of multiple risk factors has been shown to increase the likelihood that a child may experience abuse and neglect (Institute of Medicine and National Research Council, 2014). Specific risk and protective factors, and the evidence underpinning them, are discussed in further detail in chapter 5 of this report.

This research focuses on the individual relationship between a trusted adult outside of the family system (such as a practitioner or mentor) and a vulnerable child or young person, which is only one aspect of a wider set of determinants which impact on the abuse and neglect of children and young people. Interventions which address societal and community-level determinants, family-level determinants and parent-level determinants are all important parts of a holistic response to child sexual exploitation and abuse. However, they did not fall within the scope of the research for this review.

3. Methodology

Research objectives

EIF's research focused on early intervention to help children and young people who are considered vulnerable because they have indicators of risks that are thought to be predictive of CSA and CSE. Using the language of the Munro review's levels of prevention, the work considered selective primary prevention (or 'targeted selective' interventions[4]) and secondary prevention (or 'targeted indicated'[5]), and sought to identify:

- The aspects of child–adult trusting relationships that are crucial to improving children and young people's resilience and outcomes
- The features of these relationships that are most effective where children are vulnerable to CSE or CSA
- How more of these relationships could be enabled in our existing public services.

Rapid evidence overview

A transparent method was used to search the literature, focusing mainly on evidence published within the last 10 years. It is important to note that a full systematic review was beyond the scope of this research. A more comprehensive set of search terms and databases could have returned a larger set of interventions and relevant literature sources.

Our method for identifying sources included:

- contacting experts for advice on relevant literature, including in-house expertise
- hand searches of relevant journals (*Child Abuse & Neglect*, *Child Maltreatment*)
- hand searches of bibliographies of relevant sources ('reference harvesting')
- keyword searches of Google Scholar
- reviewing key government project evaluations, including those of Partners in Practice, the Social Care Innovation Fund and Disadvantaged Young People's Fund.

The evaluation evidence considered as part of this review has not been formally assessed against the EIF standards of evidence, which involves a more resource-intensive process, including a call for evidence with programme providers and a panel review process.[6] The approach used here was fit for purpose given the short timescale of the review, but it is important to acknowledge that we only made brief, initial assessments of the evaluation evidence.

4 Services and interventions that target families who are at risk, but have not yet indicated problems are described as 'targeted-selective'.

5 Services that are targeted at families who display early signs of problems are described as 'targeted-indicated'.

6 For more on EIF's evidence standards, see: http://guidebook.eif.org.uk/eif-evidence-standards. For more on EIF's programme assessment process, see: http://guidebook.eif.org.uk/about-the-guidebook/getting-your-programme-assessed

Criteria for assessing quality of evidence

Rather than undergoing the full EIF programme assessment process, the quality of evidence was determined according to some basic criteria:–

Impact evaluation evidence

- Strong: Conclusions based on multiple high-quality randomised controlled trials (RCTs) or quasi-experimental designs (QEDs), that is, RCTs or QEDs with positive findings, validated measures and sufficient sample size. No obvious threats to internal or external validity.
- Moderate: Conclusions based on one high-quality RCT or QED.
- Preliminary: Conclusions based on positive findings from one or more lower-quality RCTs or QEDs or pre-post studies.

Correlational studies

- Strong: Conclusions based on multiple high-quality longitudinal studies. That is, studies with measurement over multiple time points, large community samples, and valid and reliable measures. Prospective studies are favoured over retrospective studies. No obvious threats to internal or external validity.
- Limited: Conclusions based on one or two high-quality longitudinal studies or several lower-quality longitudinal or cross-sectional studies.

Qualitative studies

- Strong: Conclusions based on multiple high-quality qualitative studies. That is studies with well described methods, a well thought-out sampling method, and sufficiently large sample. Findings are generalisable to the research questions in this review.
- Limited: Conclusions based on one high-quality qualitative study or several lesser quality qualitative studies. 'Lesser quality' qualitiative studies may for example refer to studies based on findings with poorly described methods, or from small or non-representative samples.

The nature of the evidence imposes some limitations concerning the kinds of conclusions that can be made, regardless of the *quality* of evidence. For example, a high-quality qualitative study may provide good evidence that a particular practice is held to be beneficial for vulnerable children in a particular group, but will not directly provide causal evidence that this practice does bring about benefits for children. The reverse is true for a high-quality RCT or QED. Quantitative studies may also be less suitable for uncovering the reasons for why a programme or practice does or doesn't work.

Consultation with practice stakeholders

Our research also included qualitative research with a small sample of practitioners and practice leaders. This was intended to explore how the provision of trusted relationships in existing public services could be secured and delivered at scale.

This research included:

- structured interviews with 13 stakeholders from the police, NHS, local government, the Troubled Families programme, and the voluntary sector, to identify current practice, opportunities and challenges
- a focus group of police, early help and public health managers, to deepen understanding of practice on trusted relationships and emerging ideas

- discussions with national 'sector connectors' and leaders to test the receptiveness of the public services context for a focus on trusted relationships.

The full qualitative research report describing the results of the structured interviews and focus group is published separately on EIF's website.[7]

7 Available at: http://www.eif.org.uk/publication/building-trusted-relationships-for-vulnerable-children-and-young-people-with-public-services

4. Finding 1:

There is a strong logic for thinking that trusted relationships between a practitioner and a child can protect vulnerable young people from CSE or CSA, but as yet no evidence to support this

The importance of trusted relationships to child development is well established

There is strong evidence that supportive adult–child relationships are essential for child wellbeing (Magnusson & Stattin, 2006; Scales et al, 2006). Also, supportive relationships from caregivers or between adult partners in a romantic relationship are associated with improved long-term outcomes and improved resilience to abuse and neglect.

The importance of 'social support' to outcomes for children and young people is also well established. Here, 'social support' refers to the presence of supportive relationships that may provide emotional, informational or instrumental aid (such as access to funding or services) to an individual (Hogan et al, 2002).

- Social support can enhance resilience to stress and prevent trauma-induced disorders (Southwick et al, 2005; Iacoviello & Charney 2014).
- Trusting and trustworthy behaviour and attitudes of children have been associated with children's ability to form positive supportive relationships (Rotenberg et al, 2013; Betts & Rotenberg, 2008).
- On the flipside, there is also evidence that inadequate social support in childhood can contribute to the development of psychological problems in children (Thompson et al, 2015).

The social support provided by trusted relationships is associated with better outcomes for children who are vulnerable to abuse and neglect

There are two main mechanisms via which social support is hypothesised to support vulnerable children to avoid becoming victims of CSE or CSA (ibid; Cohen & Wills, 1985):

- as **stress-protective**: allowing children to avoid risky situations
- as **stress-buffering**: helping them to overcome adverse circumstances.

However, child abuse and neglect can cause children to resist social support. By doing so, they can become isolated, and in turn more vulnerable to revictimisation and negative life outcomes (Thompson et al, 2015). For example, in a longitudinal prospective cohort study in the US, Sperry & Wisdom (2013) found that children who are abused and neglected tend to have less social support over their life, which mediates the relationship between their adverse experiences and poor mental health. In a longitudinal study, also from the US, Oshri et al (2016) found that the presence of social resources was predictive of resilience among children who had been investigated for maltreatment.

There is also some evidence from longitudinal research that maltreated children who have safe, stable and nurturing relationships are less likely to become perpetrators themselves (Schofield et al, 2013).

Social support also has a role to play in preventing parents engaging in abuse and neglect. Physically abusive parents are more likely to experience low social support, high stress and social isolation (Crouch et al 2001; Thompson et al, 2015). Social workers and interventions often seek to prevent abuse by attempting to build up the parents' social support (Thompson ibid).

Trusted relationships between practitioners and children are not the only source of social support

The social support provided by a trusted relationship is not limited to practitioner–child interaction, and may also be provided through peers, family and romantic partners (Thompson et al, 2015). Not all children have the same access to the benefits that social support can provide, and there is some evidence to suggest that disadvantaged children and their families are less likely to receive social support in a variety of different ways (Evans, 2004). We identified some limited evidence from cross-sectional research in the US that disadvantaged neighbourhoods are associated with higher general levels of mistrust (Ross et al, 2001).

The absence of trusted relationships is consistently cited in reviews of failures around CSE and CSA

The importance of a trusted relationship between vulnerable or abused children and practitioners was highlighted in four major multi-method qualitative reviews of CSA and CSE in the UK (Warrington et al, 2016; Ofsted, 2016; Berelowitz, 2013; Jay, 2014). Predominantly drawing on vulnerable children and young people's voices, the importance of trusted relationships was highlighted in the following ways:

- Children vulnerable to CSE or CSA are less likely to trust adults.
- Relationships between practitioners and vulnerable children are often changing and short-term, which compounds vulnerable children's difficulty in trusting adults.
- Building trust is key to engaging and maintaining relationships with vulnerable children.
- The presence of a trusted relationship is a key facilitator of disclosures of abuse or exploitation.

A trusted practitioner–child relationship is an essential part of programmes that aim to support vulnerable children

A supportive, trusted practitioner–child relationship is an important component of therapeutic and family-centered interventions that are designed to support vulnerable and abused children. For example, establishing and maintaining trust is a key component of Trauma-Focused Cognitive Behavioural Therapy (CBT), which is a well-evidenced programme for victims of abuse and neglect (Cohen et al, 2012).[8]

There is strong evidence that a positive practitioner–child relationship (or 'therapeutic alliance') is consistently associated with positive child outcomes (Shirk & Karver, 2003; Zorzella et al, 2015).

8 For more on the evidence-base for Trauma-Focused CBT, see the EIF Guidebook: http://guidebook.eif.org.uk/programme/trauma-focused-cognitive-behavioural-therapy

What is not known is the extent to which the relationship is an active component in the success of such programmes, or whether the relationship is an enabling factor which supports the delivery of a successful intervention.

Practitioners also emphasised the importance of trusted relationships

A trusted relationship was viewed by practitioners and commissioners participating in our qualitative research as being fundamental to the successful delivery of a service which depends on the effective engagement of a vulnerable child or young person. It was described as being key to achieving a successful outcome for a child or family – 'you can't achieve anything else if you don't' – and to ensuring that children and young people are confident about discussing their concerns and disclosing issues, or providing a full and accurate account (in the case of the criminal justice system).

Participants told us that the importance of a trusted relationship depends on the level of need and vulnerability of a child or young person. For this reason, the need to build a trusted relationship with young people who have been through the care system and previously been let down by adults was particularly emphasised. In these circumstances, it was said that a trusted relationship can help to reverse the damaging effects of these experiences and to support the emotional development of a child or young person. Without learning how to form a positive relationship there is a danger that a child may reach adulthood unable to trust anybody, which could have a lasting impact on their lives.

While the type of relationship may vary, participants felt it was important to build trusted relationships at any point on the continuum of need. That is to say, it is as important for a child to feel able to discuss a concern at school (at the universal end of the spectrum) as it is for them to be able to talk through more complex needs and problems with a specialist service provider (at the targeted end).

It was also said that the earlier a trusted relationship can be established the better, as it may help to prevent problems developing or escalating. For this reason, it was viewed as a priority for universal services and early help teams, where workers are taking on a lead professional or key worker role with individual children and young people.

According to our participants, the key to a professional trusted relationship is that it provides the time and opportunity for a young person to talk through their feelings and worries, and to uncover and explore deeper or hidden issues. The process of discussing these issues can help them to realise that sometimes things go wrong which are not their fault, and that there may be things they can do to resolve them. By enabling a young person to 'open up', a professional can support and enable them to feel better about their situation, as well as providing information, advice and guidance. The offer of support and acceptance can also have a beneficial impact on a child's own level of self-acceptance and self-confidence.

Depending on the context in which a trusted relationship is being built, it was suggested that resilience and outcomes can be improved through:

- encouraging a child or young person to persevere when they are struggling with something
- giving them a safe and non-judgmental space in which to challenge and explore things that they may be concerned about or not agree with
- exposing them to alternative possibilities and perspectives, which can help to raise their aspirations and broaden their options

- enabling a child or young person to realise that the issue they are dealing with is 'not okay', and to raise their awareness about the risks associated with a particular situation or behaviour
- helping looked-after children to feel less isolated, as they come to understand that they can share a problem or concern and ask other trusted people to help them overcome it.

There is some evidence that supportive practitioner–child relationships can improve child outcomes in and of themselves

Mentoring approaches are varied, but broadly aim to improve outcomes for children through advice and guidance, provided by an adult with whom they build a trusting and supportive relationship over time. Evaluation research on formal mentoring programmes has shown evidence that some can bring about small but significant improvements for children (DuBois et al, 2011; Eby et al, 2008; Eby et al 2013; Durlak et al, 2010). This provides preliminary evidence that a supportive practitioner relationship, without any formal therapeutic components, can provide benefits to children.

However, the evidence depends on the programme in question, with some providing no benefit and others being shown to do harm (Grossman & Rhodes, 2002).

In addition, the UK evidence-base on mentoring is still underdeveloped. A systematic review of social and emotional learning programmes being implemented in the UK found that only one out of 11 mentoring programmes was found to be well evidenced (Clarke et al, 2015).

As yet there is no empirical evidence that the provision of a practitioner–child trusted relationship can protect vulnerable children from becoming victims of CSE or CSA

We were unable to find any evidence that directly shows that a trusted practitioner–child relationship can prevent child sexual abuse or exploitation. However, the underlying hypothesis is plausible, based on our knowledge of the importance of trusted relationships to normal child development and research into past failures around CSE and CSA. Our qualitative research also shows how attempts to build trusted relationships between vulnerable children and practitioners are embedded in current practice; although this doesn't provide evidence of effectiveness, it does demonstrate a consensus around the hypothesis.

5. Finding 2:
There is a lack of high-quality research evidence on the risk and protective factors for becoming a victim of CSA or CSE

Two risk indicators have strong evidence of a link with CSA or CSE: being disabled and being in residential care

EIF has previously conducted a rapid evidence assessment (Brown et al., 2016) that aimed to establish what is known about the risk and protective indicators of children vulnerable to CSA or CSE. It was designed to provide practitioners with an improved understanding of the factors that have been shown to differentiate between victims or perpetrators of CSA or CSE and comparison groups (such as those who have not been sexually victimised).

This is important because there are many studies that examine factors in groups of victims or perpetrators, but which do not then examine the same factors in similar comparison groups who have not experienced CSA or CSE. This means it is not possible to conclude whether the indicators identified in the victim/perpetrator samples are present at higher or lower rates than would normally be expected.

This review found that two indicators of increased risk of becoming a victim of CSA or CSE were supported by strong evidence:

- **Being disabled:** A systematic review to establish the risk of violence, including sexual violence, found that disabled children in all settings are a high-risk group, with children with intellectual or mental disabilities having a higher risk than children with other disabilities (Jones et al, 2012). Another study found associations between adult autistic traits and lifetime experience of abuse, trauma and post-traumatic stress disorder, and stated that even subtle deficits in information processing ability in children may increase these risks (Roberts et al, 2015).
- **Being in residential care:** A Dutch study found higher prevalence rates of sexual abuse in out-of-home care than in the general population (Euser et al, 2013). In the UK, two qualitative studies explored why residential care is associated with an increased risk of sexual victimisation, including factors such as multiple placement moves and the normalising of peer sexual abuse and violence (Coy, 2009; Green & Masson, 2002).

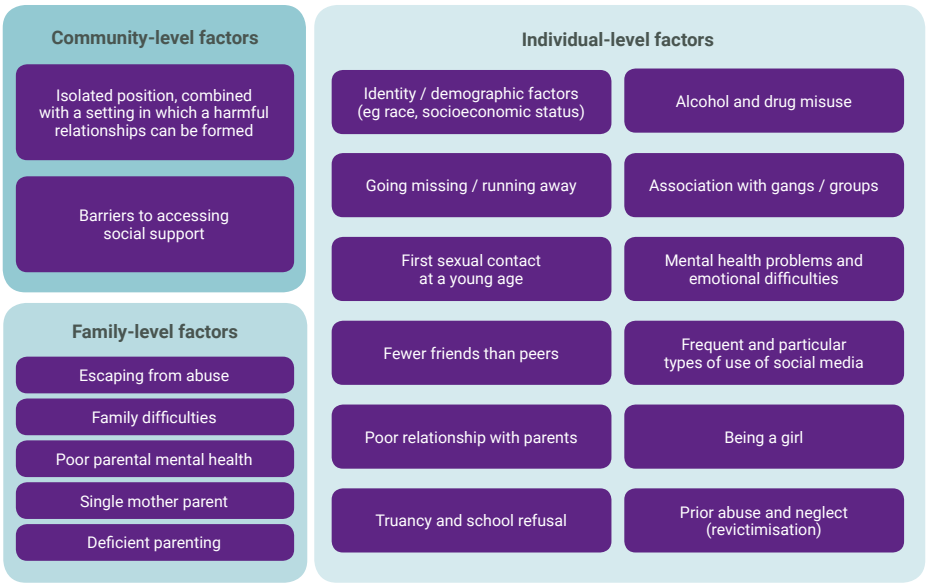
The authors of the previous EIF review noted that '[caution] needs to be exercised in interpreting these findings as there is a great deal of variability in disabled children and residential care populations, with some children potentially being at greater risk than others. The routes to becoming a victim of CSE or CSA are many and varied, involving a complex interplay of factors, and so neither of these indicators should be regarded as causal or necessary for CSA or CSE' (Brown et al., 2016: 14).

Additionally, although not directly addressed by this report, it is important to keep in mind that risk factors may differ between groups vulnerable to CSA and those vulnerable to CSE.

On the whole, however, there is a lack of high-quality research evidence on the risk and protective factors for becoming a victim of CSA or CSE

As set out in figure 5.1, a wider set of risk factors with more limited evidence have been identified by other studies, including Brown et al (2016), Jay (2014), Finkelhor (1997), and Institute of Medicine/National Research Council (2014). These are considered to have 'limited' evidence due to small sample sizes, specific samples with generalisation issues, a lack of comparison groups, or the use of self-reported data.

FIGURE 5.1: RISK FACTORS FOR CSE OR CSA WITH MODERATE OR LIMITED EVIDENCE



Source: EIF, based on Brown et al (2016), Jay (2014), Finkelhor (1997), and Institute of Medicine/National Research Council (2014)

Brown et al suggest that, while they can theorise that the absence of the risk indicators discussed above may indicate reduced risk of victimisation, there is currently no evidence to support the identification of any variable that specifically or independently indicates a reduced risk.

The lack of high-quality research evidence suggests that a broader assessment of vulnerability is needed if children and young people who are vulnerable to CSA and CSE are to be reached

The evidence for the upstream risk factors related to child sexual abuse and child sexual exploitation currently provides limited assurance as to the ability of public services to target with precision those children and young people who are vulnerable to these forms of abuse.

Risk assessment tools and checklists are not based on strong evidence, and should therefore be used to structure rather than replace skilled professional judgment and decision-making.

6. Finding 3:
There is broad consensus between research and practice on the features which allow trusted practitioner–child relationships to develop

There is no formula, but there is some evidence about which factors are associated with successful practitioner–child relationships

Identifying general factors that help to build positive practitioner–child relationships is challenging given the different ways in which children relate and respond positively to adults. However, there is some evidence about relational practice in the wider literature.

It is important to note that these factors may be more or less important depending on the specific characteristics of the child and practitioner. For example, engaging in play may be important to a young child but not to an adolescent. Some of these factors may be more important to children who have experienced harm than to those who haven't, and vice versa. Care must therefore be taken in assuming factors that are important to some groups of children and young people are also important to others.

An ethnographic study (Winter et al, 2016) looked at how social workers can effectively communicate and build relationships with vulnerable children and young people under the age of 18. It identifies factors such as:

- reflecting on shared past experiences
- use of compliments
- combining challenging with safer topics of discussion
- being responsive to the interests of the child or young person
- practitioners reflecting on what works in engaging children and young people
- pracitioners being open about their preferences for the kinds of children and young people that they like to work with.

A meta-analysis (DuBois et al, 2011) on what makes mentoring programmes more likely to be effective identified factors such as:

- the practitioner advocating for a young person
- practitioners and young people being matched based on similarities of interests
- practitioners and young people being matched based on similarity of occupational or educational background.

Qualitative findings from interviews with children who had experienced sexual abuse (Warrington et al, 2016) identified the *quality* of the therapeutic relationship as more significant than the particular model or approach adopted. The research highlighted the following factors as being important for developing trust with a professional:

- safety: the practitioner is able to create a safe space in which the child feels able to open up

- genuine and persistent care and compassion
- choice and control: children want to feel a sense of agency and control over their situation; practitioners should involve them in decision-making
- advocacy and being believed: not only do children want their story to be believed, but professionals need to be willing to advocate on their behalf
- honesty and authenticity: in order to develop a trusting relationship, the child needs to be able to trust what the practitioner says and what their motives are
- signposting: practically speaking, it was helpful if practitioners were able to accurately signpost children to other appropriate services.
- On the flipside, support that doesn't take account of the need for a relational aspect was seen as unhelpful, because it can appear harsh or unfeeling.

The importance of a 'therapeutic alliance' has very strong evidence from meta-analyses of large numbers of studies which show a robust and moderate correlation between a therapeutic alliance and the outcome (Horvath et al, 2011); and that it is the therapist's rather than the patient's contribution that predicts the outcome, meaning that therapists who were able to form better alliances generally with their patients had better outcomes (Baldwin et al, 2007).

Building a therapeutic alliance is part of the training of therapists and psychologists. It calls for the following elements, which are similar to those identified in the wider literature on building trusted relationships:[9]

- an emotionally charged bond between therapist and client
- a confiding healing setting in which the therapy takes place
- a therapist who provides a psychologically derived and culturally embedded explanation for distress
- an explanation that is adaptive, providing viable and believable options for overcoming difficulties, accepted by the client, providing hope
- a set of procedures or 'rituals' in which the client and therapist engage and which lead the client to enact something that is positive, helpful or adaptive.

These factors for successful relationships are already embedded in professional advice and guidance

A range of standards exist across service areas which formalise the role of trusted relationships in wider practice.

The College of Policing's Competency and Values Framework sets out the nationally recognised behaviours and values expected of everyone working in policing.[10] The framework directly addresses the importance of trusted relationships, talking about being 'genuine with those we communicate with and endeavour to create trusted relationships', noting that 'acting with compassion, sensitivity and warmth … helps to drive and maintain public trust'.

Ofsted published a joint inspectorate review in 2016 called 'Time to Listen', based on lessons about effective practices which aimed to tackle child sexual abuse in five local areas.[11] The review is explicit about the importance of trusted relationships to children who are at risk, and highlights that:

9 For more detail see Laska et al (2014).

10 Available at: http://www.college.police.uk/What-we-do/Development/competency-and-values-framework/Pages/Competency-and-Values-framework.aspx

11 Liverpool, Croydon, Central Bedfordshire, Oxfordshire and South Tyneside. Available at: https://www.gov.uk/government/publications/joint-inspections-of-child-sexual-exploitation-and-missing-children-february-to-august-2016

- Practitioners need to be sensitive and understanding to develop a trusting relationship with a child.
- In the context of CSE, inappropriate language (such as 'promiscuous', 'consensual', or 'small age gap') is a key barrier to developing trusted relationships.
- Children want to feel they are in control of their situation. Effective practitioners carefully plan their work together with the child and are persistent and skilled in engaging children in the process.
- While children value having a trusting relationship with one adult, having too many professionals involved in direct contact with the child can be unhelpful and overwhelming.

The professional values in the Youth Work National Occupational Standards[12] stress choice, respect, valuing difference, being concerned with how young people feel, treating them as a partner, and empowering their voice (see figure 6.1). The first standard describes how youth workers should 'initiate, build and maintain purposeful relationships with young people'; it includes detailed performance criteria and a description of the knowledge, understanding and behaviours required.

The Life Programme, which was influential in the development of the Troubled Families Programme, was fundamentally built around relational practices (Cottam and James, 2013). Defined core competencies (see figure 6.2) of Life team members used descriptors such as being loving, cobuilding capabilities, and 'development not fixing', and described personal characteristics such as nurturing, caring, collaborative, curious, perceptive, resilient, supportive and challenging.

12 Available at: http://www.nya.org.uk/wp-content/uploads/2014/06/National-Occupation-Standards-for-Youth-Work.pdf

FIGURE 6.1: EXCERPT FROM THE YOUTH WORK NATIONAL OCCUPATIONAL STANDARDS

LSI YW01
Initiate, build and maintain purposeful relationships with young people

NATIONAL OCCUPATIONAL STANDARDS

Overview

Purposeful relationships with young people are at the heart of good youth work. It is important to know how to initiate such relationships and also the ways in which they can be maintained in order for learning and development to take place.

This standard is about initiating, building and maintaining personal relationships with young people and is for all youth workers.

Performance criteria

You must be able to:

P1 identify and utilise suitable locations and environments for establishing contact with young people
P2 initiate and hold conversations at an appropriate time and place
P3 communicate effectively with young people
P4 provide on-going support and encouragement to young people
P5 respond appropriate to needs of, and issues raised by young people
P6 facilitate young people's proposals and plans
P7 maintain appropriate ethical, legal and contractual requirements in all dealings with young people
P8 meet the values and principles underpinning youth work in all dealings with young people

Knowledge and understanding

You need to know and understand:

K1 legal, organisational and codes of practice relevant to working with young people, and their impact for communicating and dealing with young people
K2 locations in the community where young people meet
K3 the importance of building trust and rapport with young people, and methods for achieving this for a range of young people
K4 different styles and forms of communication that may be appropriate for communicating with young people, including electronic channels
K5 the importance of non-verbal communication, such as body language, and how others use and interpret body language in different ways
K6 possible barriers to communication, their causes, and ways to overcome them
K7 the importance of ensuring understanding and of avoiding assumptions
K8 typical issues, concerns and activities of relevance to young people
K9 the potential risks to own personal safety, and ways of addressing these
K10 requirements regarding confidentiality, and the importance of meeting these
K11 the boundaries of own personal competence and responsibility, when to involve others, and how to obtain advice and support
K12 the values and principles underpinning youth work

Source: National Occupational Standards (2014)

FIGURE 6.2: CORE COMPETENCIES OF LIFE TEAM MEMBERS

Fundamentals	Characteristics	Capabilities
Being loving	Nurturing Caring Compassionate	Ability to build real relationships based on trust and mutual respect Ability to model loving relationships Ability to understand importance of family relationships and dynamics
Being the change	Self-aware Authentic Perceptive	Ability to share their own experiences, have insight into their own needs and manage the impact of work on them Ability to use self professionally
Team not a Key Worker	Collaborative Communicative Insightful	Ability to work closely and collaboratively with families, Life Team colleagues and professionals in the wider system
Co-building capabilities	Positive Empowering Reflective	Ability to help people discover and develop their strengths, overcome barriers and learn from setbacks
Development not fixing	Curious Patient Perceptive	Ability to reflect, generate insights and support families to do the same Ability to hold close relationships with families but still 'see the bigger picture'
Offering an open invitation	Resilient Persistent Supportive Challenging	Ability to be non-judgmental, open and honest with families Ability to motivate and support others Ability to challenge when needed
Being family-led	Creative Flexible	Ability to encourage and support decision-making and planning in others

Source: Cottam and James (2013)

These factors for successful relationships are already understood by practitioners

The reflections of participants in our qualitative research on what is key to developing a trusted relationship varied according to the type of service they provided and the complexity of need that they worked with. Their experiences range from early help practice supporting children with a low level of need for a limited period, through to working with children with more complex issues who require more regular contact over a longer duration. It was said that in every service there is some sort of trust that is established, but that it often tends to be time-limited, fragmented and confined to office hours or within a prescribed delivery model, with limited opportunities for taking a more holistic approach.

Participants told us that time is critical to building a trusted relationship. While a relationship can be established very quickly, this is likely to vary according to the nature and reason for the engagement, the skills of the practitioner and the complexity of the child's needs. It will take longer to build rapport and earn the trust of a child who has been looked after or has more complex needs. This will have implications for the appropriate caseload and duration of contact.

It was also felt that practitioners need to be flexible about how they use their time. There may need to be a higher level of intensity at the start of the relationship in order to build trust and rapport and to demonstrate a commitment to the child. Once the relationship and trust has been built then it may be possible to reduce the level of contact, if not the duration of time.

Participants noted that it may be helpful to use different approaches and models for developing a trusted relationship based on the duration of contact a practitioner will have with a child. A practitioner building a relationship during a brief encounter may require a different approach to those working over a longer time and/or greater number of sessions.

It was also seen as important that a practitioner can be available when the young person needs to speak to them, without creating dependency. This demonstrated the commitment of the practitioner and their concern for the child or young person.

According to our participants, consistency or continuity of care is one of the most important aspects of a trusted relationship. Children want to see the same person, because it takes time to build trust and working with different professionals requires them to 'tell their story' repeatedly. Consistency was felt to be particularly important for children who have been let down in the past in their relationships with adults.

Another key is professional reliability: the importance of the practitioner delivering on what they say they will do and not letting the young person down. This means being open and honest about the professional limitations of the relationship and never dodging an issue or making a promise, even if it is one that can be kept.

More broadly, the quality of the relationship was identified as essential to building trust. An effective relationship requires being non-judgmental, having empathy and good communication skills, and actively listening to the young person. A practitioner also needs to convey a genuine interest in the child or young person. It may be helpful if the professional is able to share some part of their own life with the child, if the context is appropriate and within limits.

The importance of working with an individual child in multiple different contexts was also highlighted, covering school, home, clinical and social situations. This provides the opportunity to build a more holistic understanding of how children

react and behave, by engaging them in different activities and contexts. It also helps the child to associate the practitioner with different environments, and teaches them that 'relationships can criss-cross all aspects of their life'.

Prior to meeting the child, it was seen as helpful to develop an understanding of their background and family context to build a profile. However, this has implications for the systems and processes which allow the sharing of personal information. With younger children, it may also help to actively involve a parent (that is, beyond simply seeking their consent) to encourage the child's initial engagement.

Our participants noted that it is easier to build a trusted relationship in circumstances where children and young people are voluntarily engaging with the service or committed and willing to engage. One aspect of this is ensuring that young people feel safe, by explaining the boundaries of the service and the relationship, and reviewing these at the right time. Another aspect is being child-centred, responding to their interests using age-appropriate activities, and communicating on their terms. This means spending time with children and young people in environments they feel comfortable in, working on their agendas and at their pace to identify issues of concern, and supporting them to come up with solutions to improve their lives.

7. Finding 4:

The ability of public services to build trusted relationships with vulnerable children and young people appears to be influenced by the characteristics of the child or young person, the practitioner and the organisational context

A range of studies show how child or family factors can influence trusted relationships between a young person and a practitioner

A study exploring factors that impact on the therapeutic alliance in the context of psychotherapy found that child gender and symptoms were important factors predicting the quality of the alliance (Zorzella et al, 2015). In this particular study, girls and children with internalising problems were found to develop a stronger alliance early on in the treatment process.

However, a meta-analysis exploring the effectiveness of mentoring programmes found that those programmes serving larger proportions of females relative to males showed weaker results. In this instance the authors were unable to conduct supplementary analyses to account for this trend. Possible reasons for the different effects could be, for example, that girls who were referred to mentoring programs have been found to 'report significantly lower levels of trust and greater feelings of alienation in their relationships with parents than do boys … a tendency that could potentially generalize to their relationships with other adults such as mentors in ways that are counterproductive' (DuBois et al, 2011).

Gender is therefore an important factor to consider, as there do appear to be differences in how boys and girls develop trusting relationships in different contexts.

Moreover, the meta-analysis focusing on mentoring found that mentoring programmes tended to be more effective for young people who have a high proportion of behavioural problems rather than internalising problems (ibid).

In the mentoring literature, younger adolescents report better friendships and more disclosure with adults (Thomson & Zand, 2010) and tend to have more enduring ties with programme-assigned mentors (Grossman & Rhodes, 2002) than do older adolescents.

Mentoring programmes tend to be more effective if they are targeted at young people from low-income backgrounds (Dubois et al, 2011). Qualitative literature highlights that resistance from families may be a barrier to the implementation of a programme (Winter et al, 2016).

Our qualitative research suggests that some practitioners are more naturally suited to engaging and relating to young people

Despite the range of different sectors covered in the qualitative research conducted for this review, there was considerable agreement about the critical characteristics and skills needed to build a trusted relationship. While it was acknowledged that it is possible to develop the skills required to build trusting relationships, it was felt that some people are naturally better suited to doing this than others. It was felt that the workers who are more successful at building a trusted relationship are more gifted at engaging and relating to young people. They were said to be able to naturally relate to children and communicate more simply and easily, using terms and words that they understand. It was emphasised that this is not about being trendy and trying to be 'one of the mates'; it is about being personable and friendly, and able to build the relationship within a professional boundary.

The attributes and characteristics that were commonly identified as being important include being warm, empathetic, approachable, having a sense of humour, being self-aware, patient, a good listener, tolerant, non-judgmental, having the ability to challenge without getting people upset or causing aggression, being calm, tenacious, emotionally intelligent, resilient, genuinely committed to working with young people, and 'in it for the long haul'.

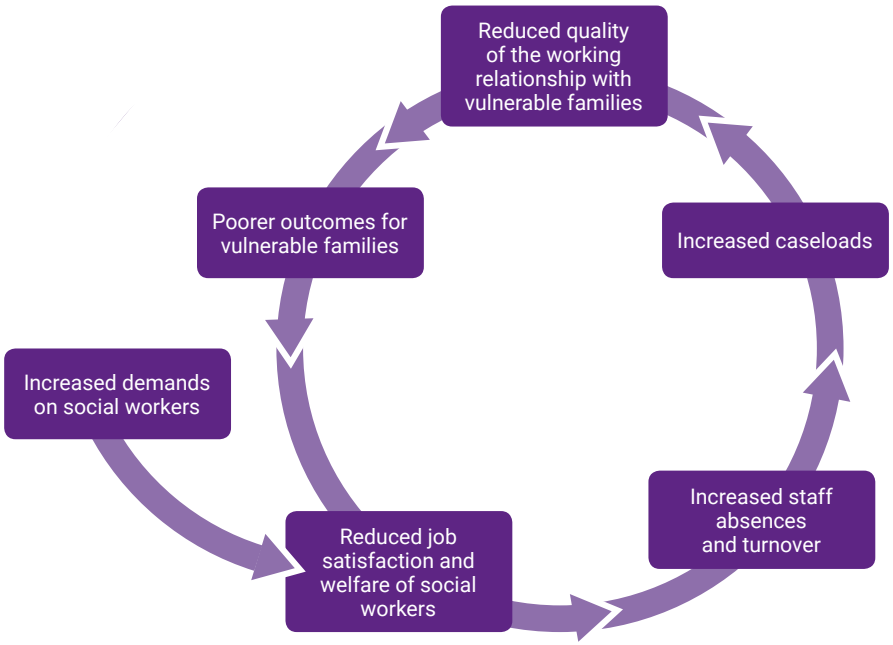
Participants also reflected on the range of skills that people need to build a trusted relationship, and the toolbox of techniques for working with children of different ages and with different needs. The goal was to enable, motivate and encourage children and young people to tackle their issues and build their confidence by helping them to recognise and achieve solutions. Suggestions included a basic grasp of cognitive behavioural therapy, coaching and mentoring approaches, basic counselling skills, motivational interviewing, solutions-focused therapy, unconditional acceptance, Signs of Safety, and other strengths-based approaches and restorative practices.

The impact of contextual factors on trusted relationships is defined and understood in social work

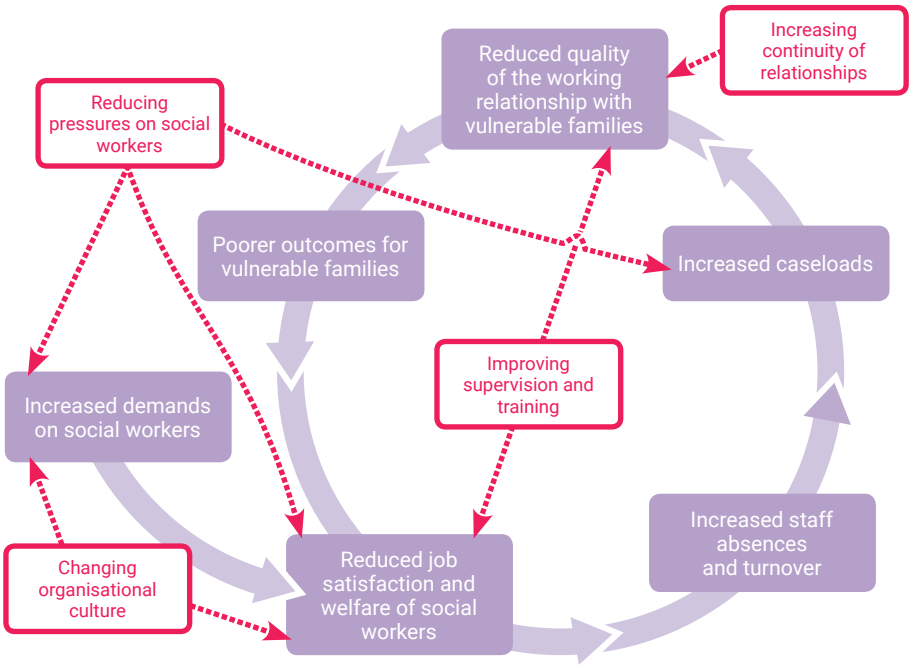
The Munro review in 2011 highlighted how demands on social workers such as excessive focus on bureaucracy and a lack of autonomy impact on the quality of their working relationships and so can lead to worse outcomes for vulnerable families (Department for Education, 2011). Social work is commonly highlighted as a stressful profession with a high probability of burnout (Kinman & Grant, 2011; Lloyd et al, 2002). The review highlighted that increased demands on social workers were contributing to the elevated turnover and absences rates seen in the profession. This was described as leading to increased caseloads, less time working with vulnerable families, and a poorer therapeutic alliance with vulnerable families, the consequence of which was worse outcomes and further decreases in social worker job satisfaction and welfare. These interactions are summarised in figure 7.1.

FIGURE 7.1: ADDRESSING CONTEXTUAL FACTORS IN SOCIAL CARE PRACTICE

CYCLE OF UNDERLYING FACTORS



OPPORTUNITIES TO ADDRESS UNDERLYING FACTORS



Source: Adapted from Department for Education (2011)

The Victoria Climbie enquiry (Laming, 2003) highlighted the importance of high-quality reflective supervision and training in improving social workers' resilience, helping them deal with the considerable stresses involved in social work and maintaining their capacity to reflect and help vulnerable families. Improving training and supervision can also impart techniques and skills to build better working relationships with vulnerable families.

Changing the 'social context' of teams working in mental health and social care has been highlighted as a way of improving turnover and job satisfaction (Glisson & Williams, 2015). One intervention, the Availability, Responsiveness and Continuity (ARC) organisational method, has moderate evidence from an RCT in the US of reducing turnover and improving job satisfaction in child welfare workers. It also has evidence from four other RCTs of working in other settings. No child outcomes were measured.

The importance of contextual factors to trusted relationships in early intervention is evident to practitioners

Participants in our qualitative research had strong views about the necessity of reflecting on the way services are organised and delivered so that the infrastructure is able to support the needs of children and young people more effectively. This could include developing a more integrated and streamlined approach using a whole-family key worker approach, reducing duplication and addressing information-sharing barriers. They felt that consideration needed to be given to the physical organisation of services and how this could enable more personalised and easily accessible child or young person friendly services in the community, with online backup.

Participants also felt that working practices needed to change so that practitioners could work more flexibly and be available at times when children and young people need them during the day, out of hours and at the weekend. This was seen as being likely to help maintain the relationship and demonstrate the commitment of the professional to the child or young person. It was also felt that services should explore how to provide continuity of care when a worker is off sick or not available, for example, by experimenting with team structures or buddying approaches.

Addressing organisational culture and building an understanding among staff of the importance of trusted relationships and how to sustain them were seen as critical. This needed to include making sure that managers are championing and promoting the importance of building trusted relationships as central to the aims of the service, and embedding the importance of trusted relationships within recruitment processes and workforce development and appraisal.

This review was unable to identify evidence sources which addressed the issue of the impact of contextual factors on trusted relationships in early intervention

Far less attention has been given to the importance of trusted relationships in early intervention systems and services than in children's social care. While some of the evidence about children's social care practice is potentially equally relevant to earlier intervention – for example, the learning generated from social care experience of workforce planning, recruitment and selection, skills development, supervisory practices, caseload allocation and organisational culture – the resources and demands of early help systems obviously differ from those facing the statutory children's safeguarding system.

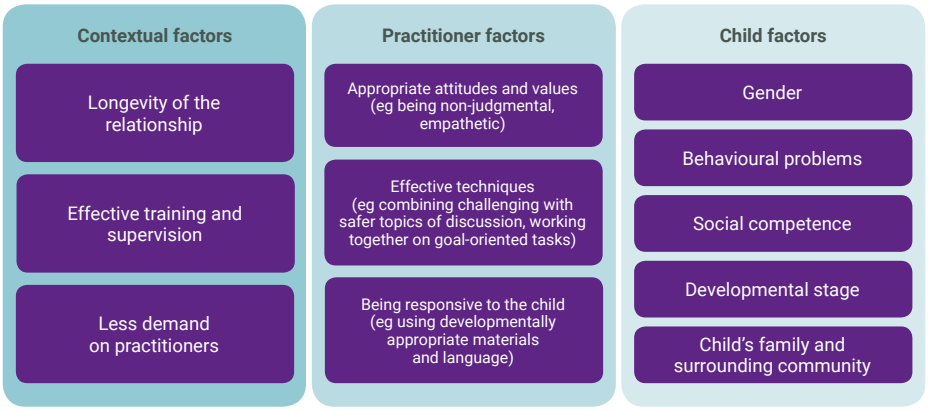
This lack of evidence about how contextual factors might influence the provision of trusted relationships in early intervention is notable given the changing context in which these services are now being delivered. Youth services, arguably a close match with the skills and methods required for building trusted relationships with vulnerable young people, have been substantially reduced. Many local areas experience recruitment and retention problems in critical sections of the workforce, and continue to rely on temporary or agency staff.

At the same time, restorative or relational practices are growing in profile – but, as yet, there is limited evidence of their efficacy, including for those which are part of the DfE's Partners in Practice programme.[13] Finally, relational practices may be under-represented in wider reorganisation and integration of children's services, as these can tend to focus more on process and transaction than *quality* of practice.

Despite the evidence gaps, there is a plausible interaction between factors at the child, practitioner and contextual levels

This reinforces the conclusion that enabling trusted relationships within public services requires a nuanced and multi-dimensional approach, taking account of the fit between a children's lived experience, the skills of practitioners, and the context in which the intervention is delivered.

FIGURE 7.2: FACTORS WHICH MODERATE THE EFFECTIVENESS OF TRUSTED RELATIONSHIPS



Source: EIF

13 See: http://springconsortium.com/partners-in-practice/

8. Finding 5:
There is good evidence for the effectiveness of high-quality mentoring approaches

There is good evidence that mentoring can be an effective method for building a trusted relationship with vulnerable young people that improves outcomes

DuBois et al (2002) define mentoring as a programme or intervention that is intended to promote positive youth outcomes via relationships between young people (18 years old and younger) and specific non-parental adults (or older youth) who are acting in a non-professional helping capacity.

The evidence on mentoring is based on:

- meta-analyses of the effectiveness of mentoring programmes (DuBois et al, 2002; DuBois et al, 2011) and a Campbell Collaboration review (Tolan et al, 2013)
- systematic reviews of the effectiveness of developmental prevention programmes in reducing delinquency, aggression and bullying (Farrington et al, 2016);
- EIF's systematic review of social and emotional learning programmes (Clarke et al, 2015);
- implementation information from US research clearinghouses on mentoring programmes such as Big Brothers Big Sisters, Friends of the Children (FOTC) and Compass.

The aim of the Campbell review was to assess the evidence to date on the effects of mentoring interventions for delinquency and the related problems of aggression, drug use and school failure. The review concluded that mentoring is as effective for high-risk youth in relation to delinquency as many other preventive and treatment approaches (Tolan et al, 2013).

Natural mentors show positive impacts, particularly in terms of child resilience

There is evidence that the presence of a natural mentor can induce small improvements in children's outcomes. A natural mentor is an older non-parental adult who provides social support, role-modelling, skills or advocacy outside of any formal intervention. Natural mentors can include extended family, neighbours, teachers and coaches (DuBois et al, 2011).

For example, DuBois & Silverthorn (2005), using data from a longitudinal study in the US, found that having a natural mentor was associated with better health, work, education and psychological outcomes. However, the positive effects were fairly small in magnitude and were not strong enough to compensate for individual and environmental risk factors.

We identified some evidence that having a natural mentor is positively associated with children's resilience. For example, Miller-Lewis et al (2013), in a longitudinal study from Australia, found that both high-quality parent–child and teacher–child relationships were associated with durable mental health outcomes.

Greenwood (2008, cited in Gill 2016) found that naturally occurring mentors are associated with child resilience in adverse conditions to a greater degree than 'professional' mentors.

Mentoring can impact on a range of important outcomes for children and young people

Meta-analysis of the evidence identifies a positive and consistent effect size for mentoring on a range of different outcomes (DuBois et al, 2011), including:

- attitudinal/motivational outcomes (such as achievement motivation and prosocial attitudes)
- social/interpersonal (eg, social skills and peer relationships)
- psychological/emotional (eg, depressive symptoms and self-esteem)
- conduct problems (eg, drug use and bullying)
- academic/school outcomes (eg, standardised test scores and absences).

However, not all mentoring programmes are high-quality or effective

As noted earlier, the evidence for mentoring programmes depends on the programme in question, with some providing no benefit and some even being harmful (Grossman & Rhodes, 2002).

In general, adult mentors who are not part of the mentee's regular social network, such as volunteers, are less effective than natural mentors (Rhodes, 2002). Volunteers tend to invest limited time and energy, and often have only a cursory understanding of relevant family and cultural issues.

Even then, volunteer programmes vary greatly in their effectiveness. Those that expect frequent contact over a long period of time between the mentor and mentee are the most successful (ibid). Youth mentoring (as opposed to workplace and educational mentoring) has also been identified as the approach with lowest effect sizes, in one meta-analysis (Eby et al, 2008). Another study, a meta-analysis by Wood & Mayo-Wilson (2012), concluded that school-based mentoring programmes did not reliably improve young people's social and emotional skills, academic achievement, attendance or behavior.

Evidence shows that more effective mentoring has specific characteristics

Our review of the evidence included three sources[14] which address the question of what is known about the characteristics of effective mentoring. In summary, the following factors have evidence of impacting on effectiveness:

- The intervention is delivered to young people with moderate levels of relational difficulties, rather than either severe difficulties or no difficulties – mentoring is not a substitute for more intensive therapeutic or educational services.
- There is a good fit between the educational and occupational background of mentors and the programme's goals.

14 DuBois et al, 2011; Clarke et al, 2015; and US clearinghouse information on the implementation of Big Brothers Big Sisters.

- Mentors are prepared and supported effectively by programmes to work with young people in ways that are aligned with the intervention's objectives – for example, through a structured manual or training in adolescent development, risk and the impact of trauma.
- Young people and mentors are matched based on similarity of interests. We found no evidence to support the practice of matching on the basis of race or ethnicity.
- There is a direct and explicit focus on the programme's desired outcomes, and provision of structured activities.
- Delivery occurs over a longer period of time, although it is unclear whether this is significant.
- Relationships are characterised by trust, mutuality and empathy.

Qualitative research shows a range of perceived benefits related to mentoring programmes

Practitioners and leaders participating in our qualitative research felt that mentoring is a very helpful way to develop a trusted relationship, so long as there is a good match between the mentor and young person; and provided that the process is clearly managed and supervised to ensure there is not an over-reliance on the mentoring relationship, which can be aided by working alongside other services. It was also emphasised that there is not 'one homogenous way' to provide mentoring: there will need to be a range of activities and approaches that are age-appropriate and reflect cultural diversity. There may also be more challenges in mentoring younger children, as it is likely to be necessary that parents are more involved, which may make the process more complicated.

Participants drew comparisons between voluntary programmes and funded programmes, which are often targeted at those with more complex needs. Many voluntary programmes were praised for encouraging engagement and employing highly committed volunteers and young people to be mentors. Indeed, voluntary programmes were seen as having an advantage, because children and families are not required to participate and are not concerned that their child will be taken away or subjected to a child protection plan.

To be effective, it was emphasised that mentoring needed to be built on a robust training programme, good supervision and a clear framework and plan, to reduce the risk that these approaches may 'drift' and ultimately fail to achieve their goals.

Our participants provided examples of where they felt mentoring was 'adding value':

- where young people do not have a positive adult relationship, are isolated and lacking a social network, or are living in a rural area
- to complement other more-tailored support being offered to a family
- with black boys, gang members, or young people who are not in education, employment or training (NEET)
- to address health and emotional wellbeing issues, build resilience, and provide support with alcohol and substance misuse.

Gaps in the evidence remain on the most effective components of mentoring approaches, and in implementation and evaluation

EIF's systematic review of social and emotional learning programmes being implemented in the UK found only one out of 11 mentoring programmes to be well evidenced, and recommended further research using stronger study designs to develop a greater understanding about the mechanisms of change which make mentoring interventions more effective (Clarke et al, 2015).

Tolan et al (2013) also conclude that mentoring is a very promising approach, but that we need to know much more about what the active ingredients of mentoring are. They suggest further evaluation of programme organisation and features, implementation variations and theories of change in order to improve understanding of this type of intervention.

UK evaluations of mentoring interventions, such as those funded by the Disadvantaged Young People's Fund, tend to be qualitative, to use measurement approaches which have weaker psychometric properties, to have small sample sizes, and to have no control or comparator groups. Improving the quality of evaluations in the UK (of mentoring, and of early intervention more generally) is as important as increasing the quantity.

There are many therapeutic/working alliance measurement tools available,[15] but there remains a lack of clarity as to which are the most appropriate for adolescent and child populations.

Participants in our qualitative research reported positively about examples of mentoring approaches being used locally. There were, however, concerns about the apparent variation in their quality and the lack of measures or a framework to judge their efficacy.

15 See for example the Working Alliance Inventory: http://wai.profhorvath.com

9. Implications for Home Office policy

EIF's research is intended to inform Home Office policy on the role of trusted practitioner–child relationships in avoiding the harm caused by child sexual abuse and child sexual exploitation. It is not designed to provide accessible advice to inform local services and practice, although the summary of the evidence set out in the preceding chapters does offer important messages that are directly relevant to practice.

The issue of how to enable a greater emphasis on trusted relationships in public services is complex, given the range of interdependent factors, rather than merely technically complicated. This means that interventions which focus on single factors are unlikely to address the system relationships and interdependencies, and therefore are unlikely to lead to sustainable change. A systemic response is needed to avoid what Reynolds & Holwell (2010) call the 'trap of reductionism', oversimplifying and avoiding the inevitable interconnectivity between variables. Simple solutions and 'the one thing' responses, while undeniably attractive, are often flawed.

This crucial observation has led to an important shift in the scope of our recommendations. Our research was initially directed to identifying evidence-based interventions or approaches that could be commissioned by the Home Office and delivered at a local level over the next few years. However, our work shows both that there is insufficient evidence for 'off the shelf' interventions to support this approach, and that increasing the availability of trusted practitioner–child relationships requires a more nuanced and systems-focused approach.

The conclusions of Farrington et al (2016) are very relevant. They looked at 50 systematic reviews of the effects of developmental prevention programmes: community-based programmes designed to prevent antisocial behaviour, targeted at children and adolescents, and aiming to change individual, family, or school risk factors). They conclude that:

- There is less need to develop more and more programmes than there is to further investigate the most promising approaches. To consolidate and advance the current evidence-base and ensure quality management in daily practice, it is necessary to take into account many factors, such as characteristics of the programme, context, target groups and evaluation methodology.
- Policymakers should further invest in systematic and large-scale approaches to promote the quality of programme implementation and sound outcome evaluation. Intervention policies should be sustainable and cross-departmental.

Participants in our qualitative research made a strong case for building capacity to develop trusted relationships and adapting the infrastructure and organisation of services rather than introducing new interventions with time-limited funding.

We have drawn three sets of conclusions from these findings, which are relevant to developing Home Office policy on trusted relationships.

1. System capability for trusted relationships

There is consensus as to the importance of relational skills in enabling practitioners to work effectively with vulnerable children and young people. However, given the funding climate and service reductions, consensus alone will not result in more trusted relationships within public services. Rather, it requires support and capacity-building at local and national level.

There is currently insufficient understanding about the most effective ways (both in terms of outcome and cost) to build systems and services around the development of trusted relationships in early intervention.

There is potential for focus on and action in the following areas.

Leadership at a national level on relational practice and systems

- Collating information on best practice and tools to support local work on professional development and system analysis
- commissioning new learning, for example on applying 'therapeutic alliance' approaches to the wider workforce
- engaging young people and local leaders in debate and action on relational system improvement.

Investing in local capacity for workforce planning and development of relational practice and systems

- Calling for local partners to test approaches to developing trusted relationship systems
- engaging areas with significant challenges in terms of current outcomes for vulnerable young people
- focusing investment on building local workforce skills and capacity for effective trusted relationships.

Demonstration sites / 'promising model' trials

- Funding pilots of a new generation of targeted, evidence-based youth interventions, with a focus on stable trusted relationships and emotional wellbeing.

2. Mentoring for vulnerable young people

Mentoring is common across child, youth and family services, and shows promise in using a trusted relationship to delivering positive outcomes for vulnerable children and young people.

There remain, however, questions about implementation, evidence, measurement and sustainability. The term 'mentoring' is used to describe a wide variety of unspecified interventions with children and young people, with little recognition of what is known about the most effective approaches. Different approaches can have very different impacts, with some even leading to harm or negative effects.

There are also some gaps in the evidence-base on the essential 'active ingredients' for mentoring, (such as intensity and duration), which are compounded by the lack of common, robust measurement approaches.

There is potential for focus on and action in the following areas.

Developing a consistent narrative on mentoring evidence, outcomes, quality and measurement, to secure greater consistency and understanding

- Producing a UK narrative on evidence-based mentoring for vulnerable children and young people
- mapping current investment and reach
- confirming quality standards, an outcomes framework and measurement tools
- drawing on international expertise relating to high-quality mentoring, including European and US centres for evidence-based mentoring.

Supporting local development of high-quality mentoring

- Tools for self-assessment against standards
- advice on commissioning, delivery and evaluation
- engagement with networks of both providers and commissioners to generate new UK evidence.

Demonstration sites / 'promising model' trials

- Calling for 'test and learn' local partners where mentoring intervention already exists and is funded, focusing on quality improvement and evaluation
- Calling for partners to deliver funded pilots, where innovation is required for specific vulnerable groups.

3. Effective implementation and evaluation

High-quality implementation of services coupled with rigorous evaluation of impact are both crucial to testing if and how new approaches can improve outcomes for children. The public service context is naturally receptive to messages about relational practice, while at the same time being both resistant to 'rush to the new' and constantly juggling a series of competing urgent priorities with reducing capacity for managing change.

Sustaining change and the ability to generate data about impact both depend on effective implementation, but translating evidence about what works into practice continues to be a challenge. There is insufficient capability at a local level to measure and evaluate trusted relationships programmes, practices and systems, yet this is vital to apply the stronger study designs that we need to build the evidence-base required for the future.

There is potential for focus on and action in the following areas.

Exploring how best to create workforce behaviour change and organisational culture change around relational practice

- For example, co-designing change approaches with key workforces, using readiness for change tools and best practice on the features of effective implementation, and avoiding the binary 'reform good, resistance bad' perspective
- addressing systems as well as investing in particular interventions.

Supporting measurement and evaluation that adds to the UK evidence-base on relational practices

- Agreeing to and embedding of key relational practice measurement tools, such as adaptations of the Working Alliance Inventory or other equivalents
- testing the impact of relational practices and systemic approaches in different parts of the local system (including police, schools, and the voluntary sector), using a counterfactual where possible.

References

Baldwin, S.A., Wampold, B.E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting & Clinical Psychology*, 75(6), 842-852.

Belsky, J. (1980). Child Maltreatment: An Ecological Integration. *American Psychologist*, 35, 320-335.

Berelowitz, S., Office of the Children's Commissioner (2013). *If only someone had listened: Office of the Children's Commissioner's inquiry into child sexual exploitation in gangs and groups. Final report*.

Betts, L. R., & Rotenberg, K. J. (2007). Trustworthiness, friendships and self-control: factors that contribute to young children's school adjustment. *Infant and Child Development*, 16(5), 491-508

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, Mass: Harvard University Press. Chicago

Brown, S., Brady, G., Franklin, A., Bradley, L., Kerrigan, N., & Sealey, C. (2016). *Child Sexual Abuse and Exploitation: Understanding risk and vulnerability*. London, UK: Early Intervention Foundation

Clarke, A.M., Morreale, S., Field, C.A., Hussein, Y., & Barry, M.M. (2015*). What works in enhancing social and emotional skills development during childhood and adolescence? A review of the evidence on the effectiveness of school-based and out-of-school programmes in the UK.* A report produced by the World Health Organization Collaborating Centre for Health Promotion Research, National University of Ireland Galway for the Early Intervention Foundation

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect*, 36(6), 528-541

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin* , 98, 310-357

Cottam, H., & James, R. (2013). The Life Programme: A report on our work, UK: Participle.

Coy, M. (2009), 'Moved around like bags of rubbish nobody wants': how multiple placement moves can make young women vulnerable to sexual exploitation. *Child Abuse Review*, 18, 254-266

Crouch, J. L., Milner, J. S., & Thomsen, C. (2001). Childhood physical abuse, early social support, and risk for maltreatment: current social support as a mediator of risk for child physical abuse. *Child Abuse & Neglect*, 25(1), 93-107

Department for Education. (2011). *The Munro Review of Child Protection: Final Report. A child-centred system*. London: Department for Education

DuBois, D. L. & Silverthorn N. (2005). Natural Mentoring Relationships and Adolescent Health: Evidence from a National Study, *American Journal of Public Health*, 95(3), 518-524.

DuBois, D. L., Holloway, B. E., Valentine, J. C., & Harris, C. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology*, 30(2), 157-197

DuBois, D. L., Portillo, N., Rhodes, J. E., Silverthorn, N., & Valentine, J. C. (2011). How effective are mentoring programs for youth? A systematic assessment of the evidence. *Psychological Science in the Public Interest*, 12(2), 57-91.

Durlak, J. A., Weissberg, R. P., & Pachan, M. (2010). A meta-analysis of after-school programs that seek to promote personal and social skills in children and adolescents. *American journal of community psychology*, 45(3-4), 294-309.

Eby, L. T. de T., Allen, T. D., Hoffman, B. J., Baranik, L. E., Sauer, J. B., Baldwin, S., … & Evans, S. C. (2013). An interdisciplinary meta-analysis of the potential antecedents, correlates, and consequences of protégé perceptions of mentoring. *Psychological Bulletin*, 139(2), 441--476.

Eby, L. T., Allen, T. D., Evans, S. C., Ng, T., & DuBois, D. (2008). Does Mentoring Matter? A Multidisciplinary Meta-Analysis Comparing Mentored and Non-Mentored Individuals. *Journal of Vocational Behavior*, 72(2), 254--267.

Euser, S., Alink, L. R. A., Tharner, A., van Ijzendoom, M. H., & Bakermans-Kranenburg, M. J. (2013). The prevalence of child sexual abuse in out-of-home care: A comparison between abuse in residential and in foster care. *Child Maltreatment*, 18(4), 221-231.

Evans, G. W. (2004). The environment of childhood poverty. *American Psychologist*. 59(2), 77-92.

Farrington, D., Gaffney, H., Losel, F., & Ttofi, M. (2016). Systematic reviews of the effectiveness of developmental prevention programs in reducing delinquency, aggression, and bullying. *Aggression and Violent Behavior*. 33, 91-106.

Finkelhor, D. (1997). The Victimization of Children & Youth: Developmental Victimology. In R.C. Davis, A.J. Lurigio, & Skogan, W.G. (eds.), *Victims of Crime* (2nd edition, 86-107), Thousand Oaks, CA: Sage Publications.

Gill, C. (2016). Community Interventions. In: Weisburd, D., Farrington, D., Gill, C. (eds). *What Works in Crime Prevention and Rehabilitation*. Springer Series on Evidence-Based Crime Policy. Springer, New York.

Glisson, C., & Williams, N. J. (2015). Assessing and changing organizational social contexts for effective mental health services. *Annual Review of Public Health*, 36, 507-523.

Green, L., & Masson, H. (2002). Adolescents who sexually abuse and residential accommodation: Issues of risk and vulnerability. *British Journal of Social Work*, 32, 149-168.

Greenwood, P. (2008). Prevention and intervention programs for juvenile offenders. *The Future of Children*, 18(2), 185-206.

Grossman, J. B., & Rhodes, J. E. (2002). The test of time: predictors and effects of duration in youth mentoring relationships. *American Journal of Community Psychology*, 30, 199-219.

Hogan, B. E, Linden, W., & Najarian, B. (2002). Social support interventions: Do they work? *Clinical Psychology Review*, 22, 381-440.

Horvath, A. O., Del Re A. C., Flückiger, C., & Symonds. D. (2011). Alliance in individual psychotherapy. *Psychotherapy.* 48(1), 9-16.

Iacoviello, B. M., & Charney, D. S. (2014). Psychosocial facets of resilience: implications for preventing post trauma psychopathology, treating trauma

survivors, and enhancing community resilience. *European Journal of Psychotraumatology*, 5(1), 239-270.

Institute of Medicine and National Research Council. (2014). *New Directions in Child Abuse and Neglect Research*. Washington, DC: The National Academies Press.

Jay, A. (2014). *Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 - 2013)*.

Jones, J., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., Bates, G., Mikton, C., Shakespeare, T., & Officer, A. (2012). Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. *The Lancet*, 380(9845), 899-907.

Kinman, G. & Grant, L. (2011). Exploring Stress Resilience in Trainee Social Workers: The Role of Emotional and Social Competencies. *British Journal of Social Work*. 41 (2), 261-275.

Laming, H. (2003). *The Victoria Climbie inquiry*. London: Stationery Office.

Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the Lens of Evidence-Based Practice in Psychotherapy: A Common Factors Perspective. *Psychotherapy*, 51, 467-481.

Lloyd, C., King, R., & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health*, 11(3), 255-265.

Magnusson, D., & Stattin, H. (2006). The Person in Context: A Holistic-Interactionistic Approach. In R. M. Lerner & W. Damon (Eds.). *Handbook of child psychology: Theoretical models of human development*, 400-464. Hoboken, NJ: John Wiley.

Miller-Lewis, L. R., Searle, A. K., Sawyer, M. G., Baghurst, P. A., & Hedley, D. (2013). Resource factors for mental health resilience in early childhood: An analysis with multiple methodologies. *Child and Adolescent Psychiatry and Mental Health*, 7, 6.

National Occupational Standards (2014). *Youth Work National Occupational Standards Introduction*, available at http://www.nya.org.uk/wp-content/uploads/2014/06/National-Occupation-Standards-for-Youth-Work.pdf

Ofsted (2016). *Time to listen – a joined up response to child sexual exploitation and missing children,* London: Ofsted.

Oshri, A., Sutton, T., Clay-Warner, J., & Miller, J. (2015). Child maltreatment types and risk behaviors: Associations with attachment style and emotion regulation dimensions. *Personality and Individual Differences*, 73, 127-133.

Reynolds, M. & Holwell, S. (2010). *Systems Approaches to Managing Change: A Practical Guide*. London: Springer.

Rhodes, J.E. (2002). *Stand by me: The risks and rewards of mentoring today's youth*. Cambridge, MA: Harvard University Press.

Rhodes, J. Lowe, S. R.; Litchfield, L. & Walsh-Samp, K. (2008). The Role of Gender in Youth Mentoring Relationship Formation and Duration. *Journal of Vocational Behavior*. 72(2), 183-192.

Roberts, A., Koenan, K., Lyall, K., Robinson, E., & Weisskopf, M. (2015). Association of autistic traits in adulthood with childhood abuse, interpersonal victimisation and post-traumatic stress. *Child Abuse and Neglect*, 45, 135-142.

Ross, C. E., Mirowsky, J., & Pribesh, S. (2001). Powerlessness and the Amplification of Threat: Neighborhood Disadvantage, Disorder, and Mistrust. *American Sociological Review*, 66, 568-591.

Rotenberg, K. J., Petrocchi, S., Lecciso, F., & Marchetti, A. (2013). Children's Trust Beliefs in Others and Trusting Behavior in Peer Interaction [Research article]. Retrieved July 20, 2017, from https://www.hindawi.com/journals/cdr/2013/806597/

Scales, P. C., Benson, P. L., Roehlkepartain, E. C., Sesma, A., & van Dulmen, M. (2006). The role of developmental assets in predicting academic achievement: A longitudinal study. *Journal of Adolescence,* 29, 691-708.

Schofield, T. J., Lee, R. D., & Merrick, M. T. (2013). Safe, Stable, Nurturing Relationships as a Moderator of Intergenerational Continuity of Child Maltreatment: A Meta-Analysis. *Journal of Adolescent Health*, 53(4), 32-38.

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review. *Journal of Consulting and Clinical Psychology*, 71(3), 452-464.

Southwick, S. M., Vythilingam, M., & Charney, D. S. (2005). The Psychobiology of Depression and Resilience to Stress: Implications for Prevention and Treatment. *Annual Review of Clinical Psychology*, 1(1), 255-291.

Sperry, D. M., & Wisdom, C. S. (2013). Child Abuse and Neglect, Social Support, and Psychopathology in Adulthood: A Prospective Investigation. *Child Abuse & Neglect*, 37(6), 415-425.

Thompson, R. A., Flood, M. F., & Goodvin, R. (2015). Social support and developmental psychopathology. *Developmental psychopathology*, 3, 1-37.

Thomson, N., & Zand, D. (2010). Mentees' perceptions of their interpersonal relationships: The role of the mentor-youth bond. *Youth Society,* 41, 434-447.

Tolan P, Henry D, Schoeny M, Bass A, Lovegrove P, & Nichols E. (2013). Mentoring Interventions to Affect Juvenile Delinquency and Associated Problems: A Systematic Review. *Campbell Systematic Reviews* 2013:10.

Warrington, C. et al (2016). *Making noise: children's voices for positive change after sexual abuse*. Luton: University of Bedfordshire/ Office of Children's Commissioner.

Winter, K., Cree, V., Hallett, S., Hadfield, M., Ruch, G., Morrison, F., & Holland, S. (2016). Exploring Communication between Social Workers, Children and Young People. *British Journal of Social Work*, 47(5), 1427-1444.

Wood, S. & Mayo-Wilson, E. (2012). School-based mentoring for adolescents: A systematic review and meta-analysis. *Research on Social Work Practice*, 22, 257-269.

Zorzella, K. P. M., Muller, R. T., & Cribbie, R. A. (2015). The relationships between therapeutic alliance and internalizing and externalizing symptoms in Trauma-Focused Cognitive Behavioral Therapy. *Child Abuse & Neglect*, 50, 171-181.