Salford Foundation's STEER Programme: a mentoring programme in Greater Manchester

An efficacy randomised controlled trial

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YOUTH ENDOWMENT FUND

About the Youth Endowment Fund

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

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

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

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

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About the evaluator

Cordis Bright was commissioned to undertake an evaluation of Salford Foundation's STEER project as part of the Youth Endowment Fund's Another Chance–themed grant round.

Cordis Bright (www.cordisbright.co.uk) believes that public sector services can change lives for the better. We work collaboratively with our clients to deliver improved outcomes for service users and their families. We provide research, evaluation, consultancy and advice aimed at improving public services. Our team has a unique combination of consultancy, research and evaluation skills, along with previous experience in practice, management, leadership and inspection. Cordis Bright offers a range of research and evaluation services which aim to improve the evidence base from which public services are delivered.

The evaluation team included:

- Dr Stephen Boxford (Director and Head of Research)
- Suzie Clements (Principal Consultant)
- Dr Jade Farrell (Senior Consultant)
- Professor Darrick Jolliffe (Associate)
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Acknowledgements

Abbreviations and definitions

Table 1. Abbreviations

	General abbreviations
2SRI	Two-stage residual inclusion
ADHD	Attention deficit hyperactivity disorder
ANCOVA	Analysis of covariance
BAU	Business-as-usual
CCA	Complete case analysis
CI	Confidence interval
EDI	Equity, diversity and inclusion
GDPR	General Data Protection Regulation
GMCA	Greater Manchester Combined Authority
IPE	Implementation and process evaluation
ITT	Intention to treat
MAR	Missingness at random
MCAR	Missingness completely at random
MNAR	Missingness not at random
PIED	Prevention, Intervention, Education and Diversion
RCT	Randomised Controlled Trial
SAP	Statistical Analysis Plan
SDQ	Strengths and Difficulties Questionnaire
SRDS	Self-Reported Delinquency Scale
SEND	Special educational needs and disabilities
SSRS	Social Support and Rejection Scale
T1	Time 1: baseline
T2	Time 2: follow-up
VCSE	Voluntary, Community and Social Enterprise Sector

Definitions

- **Family support workers** provided assistance and support to families of children on the programme, working with significant adult caregivers in the lives of the children. They aimed to provide 14 hours of support to parents/carers of the children involved in STEER across the six-month STEER intervention timescale.

- The **operational and leadership team at Salford Foundation** includes the CEO, Operational Manager and Project Manager. They collectively support the overall running of STEER.

- The **referral and assessment coordinators** at Salford Foundation were responsible for the initial meetings and subsequent administration of the outcome measures tools with children (in both the STEER and signposting groups).

- **Signposting.** Children in the signposting group were the trial's control group and received business-as-usual. This meant they were provided with signposting information about other ways to get support that were not associated with the Salford Foundation or the STEER programme.

- **STEER.** Children in the STEER group received the 'treatment': six months of mentoring support from a Salford Foundation mentor (including team leaders).

- **Youth workers/mentors (including team leaders)** at the Salford Foundation provided support to children in the STEER programme for six months. Mentors could support up to 13 children for six months. Team leaders could support up to 10 children for six months, accounting for line management time.

Statistical definitions

- **ANCOVA (analysis of covariance).** This is a statistical model used to compare average scores between groups (e.g. STEER vs signposting) while adjusting for their starting scores. It is used when the outcome is continuous (e.g. when comparing subscale scores from the Strengths and Difficulties Questionnaire).

- **Negative binomial regression.** This is a statistical model used to compare average scores between groups (e.g. STEER vs signposting), controlling for their starting scores. It is used when the outcome is a count (e.g. the number of different types of offences a child reports) and the data is more variable than expected.

- **Multiple imputation.** This is a statistical method used to handle missing data. It uses statistical software to create several complete versions of the dataset by filling in different plausible values based on patterns in the existing data. These datasets are then analysed separately, and the results are combined to give more accurate and reliable conclusions.

- **Unadjusted mean.** This is the simple average outcomes score for a group at follow-up, without accounting for any baseline differences.

- **Adjusted mean.** This is the average score for a group, calculated after accounting for differences at the start of the trial between groups (e.g. baseline scores). This gives a fairer comparison between groups.

- **Hedges' g.** This is a standardised effect size which measures the size of the difference between groups. It is a version of Cohen's *d* that adjusts for small sample sizes and ranges from 0 to 1.

- **Confidence interval (CI).** This is a range that we are fairly sure contains the true effect. For example, a 95% CI of 0.89 to 1.27 means we are 95% confident that the true result lies between those two numbers. If the range includes 1 (for ratios) or 0 (for effect sizes), the effect is not statistically significant, and we cannot determine whether the true effect is different from 0.

- **p-value.** This shows the likelihood that the observed result happened by chance. A p-value of less than 0.05 is typically considered statistically significant, meaning the result is unlikely to be due to random variation.

- **Exp (B) (exponential of the regression coefficient).** This is used in models such as logistic or negative binomial regressions. It tells us how much more (or less) likely an outcome is in one group compared to another.

  - Exp(B) = 1 means no difference in the likelihood of the outcome between groups.

  - Exp(B) > 1 means the outcome is more likely in one group than another.

  - Exp(B) < 1 means the outcome is less likely in one group than another.

- **Pearson's r (correlation coefficient).** This is a measure of the strength and direction of a relationship between two variables. It ranges from −1 to 1:

  - A value of 1 means a perfect positive relationship (as one variable increases, so does the other).

  - A value of −1 means a perfect negative relationship (as one variable increases, the other decreases).

  - A value of 0 means no relationship between the variables.

Executive summary

The project

The Salford Foundation's STEER programme is a mentoring intervention that aims to reduce children's involvement in violence. Delivered by youth workers, the programme provides four weeks of initial interactions and assessment followed by 24 weeks of weekly face-to-face, one-to-one, one-hour mentoring sessions and one hour per week of wraparound casework. Casework includes phone calls, online support and multi-agency meetings. The face-to-face sessions follow a STEER toolkit of topics. Mandatory topics include safety planning, relationships, exploitation, weapon carrying and goal setting. All parents and carers are also offered 14 hours of support from a family support worker over six months. This support aims to improve parenting skills, provide strategies to manage boundaries and improve parent communication (with both children and professionals). Sessions take place in places where children feel comfortable, including at home, at school, at the Salford Foundation offices or in the community. Children are referred for the intervention by partners, including multi-agency panels, education settings, complex safeguarding teams and the police. Children are eligible if they are aged 10 to 17 and identified as at risk of involvement in violent crime because they have an association with peers or family members involved in serious violence, organised crime or gangs. Delivery took place in six Greater Manchester boroughs: Trafford, Wigan, Manchester, Salford, Tameside and Bolton.

The Youth Endowment Fund (YEF) funded a randomised controlled trial of STEER. The evaluation aimed to establish whether STEER reduced offending behaviour (as measured by the Self-Reported Delinquency Scale [SRDS]). It also measured the impact on children's pro-social behaviours, emotional symptoms, relationships with peers and adults, and conduct problems (all measured using the Strengths and Difficulties Questionnaire). The quality of the mentor–mentee relationship was also assessed using the Social Support and Rejection Scale. Children were randomly allocated to a treatment group (which received STEER) or a control group (which received signposting to business-as-usual services). 689 children were randomised – 337 to receive STEER and 352 to the signposting group. An implementation and process evaluation was also undertaken to assess how effectively STEER was implemented, explore the key factors that influenced delivery and describe children's experiences of support. The evaluators conducted interviews with 15 children, 11 STEER project staff and 10 wider stakeholders (including local councils, police and youth justice services). Delivery data was also collected. Data collection took place between May 2022 and March 2025. 80% of the children in the trial were White, 10% were of mixed or multiple ethnicity, 4% were Asian, 3% were Black, and 3% were from an other ethnic group.

Key conclusions
STEER demonstrated **a small negative impact** on children's offending behaviour. Children who received STEER were slightly more likely to report offending behaviour than children who did not receive STEER. There is uncertainty surrounding the estimate. This result has **a moderate security rating**.
STEER showed a moderate impact on reducing emotional symptoms and a small impact on reducing peer difficulties and on improving pro-social behaviour. It demonstrated a small negative impact on conduct problems. These are secondary outcomes and should be treated with more caution.
STEER may not have been delivered at the intended intensity. Children were recorded as having received, on average, 14 one-to-one mentoring sessions versus the intended 24. Only 50% of families were recorded as having received family support, with an average of three sessions (compared to the expected 14). The reduced dosage may have played some role in preventing the programme's intended impact.
STEER staff and wider stakeholders identified a range of factors that supported effective delivery. The Salford Foundation's strong local presence, trusted relationships and involvement in multi-agency panels were viewed as enabling smooth referral and engagement processes. When expanding into new areas where relationships were still developing, referrals took longer to build. Stakeholders reported high demand for STEER.
Children who received STEER reported stronger relationships with their STEER mentors than children in the control group reported with identified trusted adults. The more mentoring sessions children attended, the stronger these relationships were. Interviews with children also suggested that mentor–mentee relationships were a consistent strength of STEER.

YEF security rating

These findings have a moderate security rating. The trial was a well-designed efficacy randomised controlled trial. It was large enough to detect meaningful impacts and larger than most previous evaluations of mentoring. 25% of children who started the trial were not included in the final analysis. We do not know whether the effect found for STEER would be the same if the children missing from the final analysis were included.

Interpretation

STEER demonstrated **a small negative impact** on children's offending. Children who received STEER were slightly more likely to report offending than children who did not. This result has a **moderate security rating**. STEER showed a moderate impact on reducing emotional symptoms and a small impacton reducing peer difficulties and on improving pro-social behaviour. It demonstrated a small negative (undesirable) impact on conduct problems. These are secondary outcomes and should be treated with more caution. There is statistical uncertainty regarding all outcomes, and the findings are also consistent with there being no impact. Exploratory analysis found no statistically significant differences in STEER's impact by ethnicity. In most boroughs, STEER reached a broadly representative group of children from ethnic minority backgrounds. Where this was not the case. STEER staff suggested this could be due to similar programmes aimed specifically at children from ethnic minority groups.

STEER may not have been delivered at the intensity originally intended. Children received an average of 14 one-to-one mentoring sessions compared with the planned 24, and only 1.5% received the full intended dose. 36% received between 12 and 17 sessions. Potential explanations for lower-than-expected dosage included STEER working with children with high levels of instability in their lives and some children disengaging early due to their involvement with a range of other services. An exploratory analysis suggested that children who attended 10 or more sessions showed slightly more favourable outcomes on offending, although this finding is uncertain and based on a small sample. Coverage of some mandatory topics was lower than planned (e.g. less than half covered criminal exploitation, 47%; safety planning, 45%; and weapon carrying, 44%), and only half of families took up family support, receiving less than a quarter of the intended sessions. Staff explained that family engagement was challenging, particularly where parents were already working with several professionals.

STEER staff and stakeholders identified a range of factors that supported delivery, including the Salford Foundation's strong local reputation and trusted relationships, its presence on multi-agency panels, its understanding of local context, clear referral pathways and the STEER toolkit. Children who received STEER reported stronger relationships with their STEER mentor than children in the control group reported with an identified trusted adult. The more mentoring sessions children attended, the stronger these relationships were. Children reported that their mentors were trustworthy and relatable and that they found the content of sessions relevant and accessible. The small number of children interviewed reported that STEER supported them in improving relationships with family members and school staff and building confidence and self-esteem, and it facilitated engagement with education or training.

Previous international reviews of mentoring have identified more positive impacts on outcomes related to children's involvement in violence. However, the findings in this study do align with the UK evidence; other mentoring studies in the UK and Ireland have failed to demonstrate an impact on offending or behaviours associated with offending. There is also a high level of variation in estimates of the impact of mentoring. This report and the primary and secondary outcome findings only present the findings of one study. When considering implications, frontline professionals, policymakers and service commissioners should carefully consider the process evaluation, the wider evidence base and their own professional judgement. The YEF has no current plans for further evaluation of STEER.

Summary of impact

Outcome	Effect size (95% confidence interval)	Impact	Evidence security	No. of children	P – value
SRDS variety score	0.08 (–0.10, 0.26)	Small negative	✓✓✓ ✓ ✓	514	0.385

1   Introduction

1.1   Overview

This report presents the findings of an efficacy study of the Salford Foundation's STEER programme. The efficacy study includes a randomised controlled trial (RCT), an implementation and process evaluation (IPE) and a cost analysis. The efficacy study also includes data collected during an internal pilot study report, which identified that the programme was ready to progress to this full efficacy study (see Section 1.2.5 for more details).

1.1.1   Summary of the STEER programme

The Salford Foundation's STEER programme (STEER) is a six-month intensive mentoring, coaching, family support and case management programme. It pairs children aged 10–17 years old who are at risk of serious youth violence and child criminal exploitation with a youth worker (mentor). Participants take part in STEER on a voluntary basis. The mentor delivers weekly face-to-face sessions (24 one-hour sessions), which follow a toolkit of mandatory and optional topics. In addition to these weekly sessions, STEER provides weekly wrap-around casework and support (24 hours of additional wrap-around support) for children and offers their parents/carers a total of 14 hours of family support to facilitate greater family cohesion.

During the internal pilot study, the STEER programme was delivered in two Greater Manchester boroughs (Trafford and Wigan). Based on the internal pilot study findings, the Salford Foundation successfully scaled up and spread the STEER programme across a further four Greater Manchester boroughs (Manchester, Salford, Tameside and Bolton), delivering in six boroughs. This scale-up was needed to achieve a sufficiently powered sample for the efficacy study.

The efficacy study, including the internal pilot study, took place between January 2022 and October 2025. Table 2 provides a summary of the efficacy study timeline.

Table 2. Summary of efficacy study timeline

Timeframes	Activity
January 2022–April 2022	Internal pilot study mobilisation
May 2022–April 2023	Internal pilot and efficacy study data collection in Trafford and Wigan
May 2023–July 2023	Internal pilot study findings and decision to progress to full efficacy study
May 2023–March 2025	Efficacy study mobilisation, scale-up and data collection[1] – scale-up was rolled out in phases: Salford began in July 2023, followed by Manchester and Tameside in August 2023, and Bolton in May 2024
April 2025–October 2025	Data analysis and reporting

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[1] Please note that there was not a pause in data collection during the transition period between internal pilot and efficacy study.

1.2   Background

1.2.1   National context and local context

The Government's Serious Violence Strategy (Home Office, 2018) recognised that *"tackling serious violence is not a law enforcement issue alone. It requires a multiple strand approach involving a range of partners."* It was delivered against a backdrop of the need for evidence about what works in preventing and/or reducing children's involvement in offending and violence. This was exemplified by the creation of the What Works Centres Network, including the Youth Endowment Fund (YEF), which is funding the STEER programme and its evaluation.

At a local level, STEER was developed by the Salford Foundation as a response to:

- An increase in the number of children involved in serious youth violence, organised crime and gangs in Greater Manchester. For instance, the number of serious youth violence offences in Manchester – one of the 10 boroughs in Greater Manchester – increased by over 200% between 2016 and 2019 (Gray, Smithson, and Jump, 2021), and 22% of perpetrators of serious violence in Greater Manchester are aged between 15 and 19 (The Greater Manchester Serious Violence Action Plan, 2020).

- An increased recognition among professionals in Greater Manchester, as reported by Salford Foundation stakeholders, of the complexity of issues displayed by children involved in serious youth violence, organised crime and gangs

- Local stakeholders reporting to Salford Foundation that the available statutory responses on their own, for a range of reasons, were not working effectively to reduce children's involvement in serious youth violence, organised crime and gangs in Greater Manchester.

- A belief amongst local stakeholders of the need to take an asset-based, trauma-informed approach to working with children on a voluntary basis, which may work more effectively than other statutory responses to prevent involvement in serious youth violence, organised crime and gangs.

- An understanding that progress for children in desisting from serious youth violence, organised gangs and crime is not a linear process (Phillips, 2017; Edward et al., 2004).

- A recognition, backed by evidence, that parents and carers can enhance protective factors which reduce the risk of children becoming involved in serious violence or crime (Wikstrom and Butterworth, 2006; Boxford, 2006).

The Greater Manchester Serious Violence Action Plan (2020) also recognised the promise of the STEER programme, which started operation in Salford in 2017:

> *"We have seen first-hand the impact that schemes offering mentoring, peer support or coaching can have in the lives of vulnerable young people. One such example is the STEER project in Salford, bringing together the police, local authority and charity Salford Foundation to provide intensive mentoring for young people who are on the fringes of involvement in gangs or organised crime".*

1.2.2   A context of disproportionality

Programmes like STEER can be important in helping to address disproportionality in the justice system. Exacerbating the need for support to children at risk of entering the criminal justice system, there is extensive evidence highlighting racial disparities within the youth justice system, which have significant implications for the experiences and outcomes of children from ethnic minority backgrounds. This was highlighted in the Lammy Review (2017), which concluded that Black, Asian and Minority Ethnic (BAME)[2] individuals still face bias, including overt discrimination, within the justice system.

The YEF's Children, Violence and Vulnerability report (YEF, 2023) underscores how children from racialised communities are disproportionately represented at key points of the criminal justice pathway. While Black children aged 10–17 make up 6% of the population (per the 2021 Census), they represented 10% of arrests, 15% of stop and searches and 24% of the average monthly youth custody population in 2023/24 (YEF, 2025). This does not mean that violence is only applicable to children from minority ethnic backgrounds: White[3] children aged 10–17 years old make up 71% of stop and searches, 76% of arrests and 72% of cautions or convictions for an offence (YEF, 2025).

These racial disparities are not wholly explained by differences in offending outcomes but reflect deeper structural inequalities, including differential treatment within the justice system, systemic racism in public services and barriers to accessing early support. Structural barriers to support and intervention exacerbate these disparities. According to JUSTICE (Paul, 2021), data suggests that White children in the UK are more likely to be offered diversionary support than children from ethnic minority backgrounds. This indicates a disparity in the accessibility and availability of early intervention, which may prevent more serious offending. In addition, an analysis by the Youth Justice Board (2024) shows there is evidence that children from racially minoritised backgrounds face structural barriers to support and are disproportionately represented in the youth justice system.

Interventions such as STEER, which offer flexible, one-to-one mentoring, are thought to be particularly well placed to respond to these inequities by tailoring support to individual experiences, building trusted relationships and strengthening engagement in education and pro-social activities (Gaffney, Jolliffe, and White, 2022). This underscores the importance of testing interventions like STEER with a diverse population.

The 2021 Census estimated that 28.7% of Greater Manchester residents were from ethnic minority backgrounds, slightly above the average in England (26.5%).

As highlighted in Table 3, the percentage of children aged 10–18 from an ethnic minority group across the six participating boroughs ranged from 7.1% in Wigan to 60.4% in Manchester (Office for National Statistics, 2021). Furthermore, the 2021 Census estimated that 58.3% of children in Greater Manchester lived in the 30% most deprived Lower Super Output Areas nationally, according to the Index of Multiple Deprivation (Greater Manchester Combined Authority [GMCA], 2023). Data on child first-time entrants in 2023 for Greater Manchester highlights that 75% are White, 11% are Black and 14% are Asian or Other. These insights

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[2] The term 'BAME' was commonly used in UK policy and research at the time of the Lammy Review. However, it has since been criticised for grouping diverse communities together in a way that overlooks distinct experiences and disparities. Many organisations now favour more specific terminology.

[3] It's worth noting that 'White' children includes children from Gypsy or Irish Traveller background, of whom, are overrepresented in the criminal justice system. This broad ethnic grouping may therefore be masking important underlying differences.

suggest the pertinence of delivering STEER in an area likely to reach a diverse group of children, including those from deprived areas and from ethnic minority backgrounds (Youth Justice Board, n.d.).

Table 3. Percentage of 10–18 year olds in each ethnic group from Census 2021 data[4]

Ethnicity	Bolton	Manchester	Salford	Tameside	Trafford	Wigan
White: English, Welsh, Scottish, Northern Irish or British	59.5%	39.6%	77.4%	78.5%	67.1%	92.9%
Asian, Asian British or Asian Welsh	27.6%	25.8%	5.5%	13.1%	17.6%	1.9%
Black, Black British, Black Welsh, Caribbean or African	6.4%	19.1%	8.4%	3.3%	4.1%	1.7%
Mixed or Multiple ethnic groups	4.3%	8.7%	5.0%	4.4%	7.6%	2.8%
Other ethnic group	2.3%	6.8%	3.7%	0.7%	3.6%	0.8%
Percentage of 10–18 year olds from ethnic minority groups	**40.5%**	**60.4%**	**22.6%**	**21.5%**	**32.9%**	**7.1%**

1.2.3 Rationale for the STEER programme

In response to the above, the Salford Foundation developed the STEER programme. The programme aims to respond to a range of research that shows that children's propensity for involvement in serious youth violence, organised crime, violence and gangs is increased by:

- Having close relationships with peers, associates and family members who are involved in serious violence, organised crime and gangs (Murray and Farrington, 2008)

- Low levels of aspiration (Mahler et al., 2017)

- Risk-taking attitudes and behaviours, such as carrying weapons (Boxford, 2006)

- Poor emotional control (Salinas and Venta, 2021)

- Low levels of pro-social values (Boxford, 2006)

The STEER programme aims to address these risk factors through intensive mentoring, case management, coaching and family support. The programme has a focus on mentoring because, when frequent and intensive, it has been shown to reduce the propensity to offend (Gaffney, Jolliffe, and White, 2022; College of Policing, 2016). Mentoring typically aims to both reduce reoffending and improve positive life outcomes (Gaffney, Jolliffe, and White 2022; College of Policing, 2016).

The STEER programme takes a trauma-informed and voluntary approach, as evidence suggests these encourage better engagement by children with services than statutory interventions for this cohort (National Lottery Fund, 2018).

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[4] This data has been derived from the Ethnicity group by age and sex in England and Wales dataset published by the Office for National Statistics. To calculate the figures, we combined the individual counts for each ethnic category across ages 10 to 18 years, for each Greater Manchester borough. Broader ethnic groupings (e.g. "White") were created by summing relevant subcategories within the dataset to match those used in this efficacy study. Percentages were then calculated using the total number of responses for each borough from the Census data.

The STEER family support offer was developed in recognition that providing parents and carers with the skills and understanding to manage risk factors and enhance protective factors can reduce serious violence and involvement in gangs (National Lottery Fund, 2018; H.M. Government, 2010). This support is also available to non-biological carers of children in the STEER programme. National Institute for Health and Care Excellence (NICE) guidance (2021) suggests that it is important that the care network around a looked-after child consists of positive relationships and that carers are provided with support services.

1.2.4   Rationale for an efficacy study of STEER

The YEF toolkit suggests that, on average, mentoring programmes similar to STEER are likely to have a **moderate** impact on violent crime. It states that mentoring is effective in both reducing crime and the behaviours associated with crime and violence, with research suggesting that, on average, mentoring reduces violence by 21%, all offending by 14% and reoffending by 19%. In line with the YEF Toolkit, there is emerging evidence that programmes that include mentoring approaches may help children stay out of crime, but more research is needed in this area (Jolliffe and Farrington, 2008).

The YEF toolkit highlights that there is a limited evidence base in the UK concerning the effectiveness of mentoring programmes on youth violence and offending. It identified two studies conducted in the UK and Ireland. One of these evaluations was an RCT of the Big Brothers Big Sisters mentoring programme with 164 children aged 10–14 in Ireland. The evaluation suggested that the programme failed to have an impact on behaviour or substance use (Dolan et al., 2011). The other evaluation was of Mentoring Plus in the UK, a programme for children at risk of social exclusion, with 378 children participating in the mentoring programme and 172 children in the comparison group. The evaluation found desirable effects on educational attainment and employability skills but no effect on offending (Shiner et al., 2004). Thus, while there is a relatively large number of studies worldwide on mentoring and its impact on offending, there is a limited evidence base in the UK and Ireland, suggesting that more research is warranted (Gaffney, Jolliffe, and White 2022).

Making sense of RCTs

An RCT is a type of study used to understand whether a programme or intervention makes a difference. In an RCT, participants are randomly assigned to one of two groups: one that takes part in the programme (the intervention group, aka STEER) and one that does not (the control group). Random assignment means that, on average, the two groups are similar before the programme begins. Any differences seen at the end can therefore be more confidently attributed to the programme itself rather than other factors.

The YEF commissions independent evaluators to carry out RCTs, ensuring that trials are designed, analysed and reported transparently. All evaluations are pre-registered with published protocols and statistical analysis plans, and the YEF releases every report, irrespective of the findings, to maintain consistency, comparability and trust in the evidence base.

What kind of results do RCTs usually provide?

RCTs usually report on whether there is a statistically significant difference between the intervention group and the control group for one or more outcomes (e.g. behaviour or well-being). Results are typically presented as an effect size – showing how large any difference was – along with a confidence interval (CI) that indicates the range within which the true effect is likely to fall. An RCT might show:

- A positive effect, suggesting the programme improved outcomes

- No detectable effect, meaning there was no clear difference between groups
- A negative effect, where the control group did better

However, these results should always be interpreted in context, considering how well the programme was delivered, whether enough participants took part and how consistent the findings are across different measures. Even when effects are small or uncertain, RCTs contribute valuable insights into what works, for whom and under what circumstances.

Why RCT results can be inconclusive but still valuable

Even a well-designed RCT can face challenges (e.g. participant dropout, missing data or programmes not being delivered exactly as planned). These issues can make it harder to detect whether a programme had an impact, even when it may have had one. Evaluators account for these factors when interpreting results.

It is important to recognise that inconclusive does not mean ineffective. It simply means that the study did not find clear statistical evidence either way – not enough to confidently say the programme worked, but also not enough to say it did not.

This is common in social and educational research. For instance, the Education Endowment Foundation (EEF) has funded more than 150 RCTs in schools, with average effects that are small or close to zero (Ashaf et al., 2021). However, within that group are many individual trials showing meaningful positive impacts. Similarly, over 80% of over 13,000 RCTs on new products or strategies in the private sector, conducted by Google and Microsoft, report no significant effect (Pfeffer and Sutton, 2006). Yet these trials still provide valuable learning about what does and doesn't work, helping to refine future approaches.

For commissioners, providers and practitioners, an inconclusive finding should not be read as proof that the programme does not work. Instead, it suggests that more evidence is needed before drawing firm conclusions. The evaluation may still provide valuable insight into implementation, engagement and context, helping local areas refine delivery or target the programme more effectively in the future.

1.2.5 Internal pilot RCT of the STEER programme

The STEER programme was evaluated through an internal pilot[5] RCT, which started in January 2022 and concluded in May 2023. Based on evidence from the evaluation, STEER was deemed ready to move to an efficacy study; the internal pilot study performed well against its progression criteria, and all aspects of evaluation feasibility were at required levels for the project to scale up. The internal pilot study report, which provides more details on the approach, methods and findings, can be seen here. Findings showed that:

- Recruitment and randomisation processes had been established and embedded effectively and worked well in practice.

- Questionnaire (outcomes measures) administration had been established and embedded successfully.

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[5] The pilot was internal in nature as the data collected during the pilot was also be used as part of the efficacy study. For more information about the differences between internal and external pilot approaches see Avery et al. (2017).

- Analysis of the data in the internal pilot study report showed that questionnaires were completed with high response rates and appeared to be reliable, valid and practical for the project.

- Based on recruitment and retention rates in the study, it was likely that STEER would meet the required sample size for an efficacy study.

- STEER had been implemented broadly with fidelity to the co-designed theory of change and STEER toolkit concerning the mentoring aspect of the programme. The internal pilot study outlined the need to improve the uptake of the family support aspect of the STEER model.

- The RCT design had been accepted, and stakeholders understood its value and importance.

As such and as summarised in Table 4, no changes to the design and methods of the evaluation were required for the efficacy study. In terms of the intervention, the Salford Foundation scaled up STEER at pace to deliver in an additional four boroughs in Greater Manchester (Salford, Tameside, Manchester and Bolton). The only change to the evaluation, at the YEF's suggestion, was the removal of the Time 3 (T3) questionnaire (which looked at changes in outcome measures six months after completing STEER, or the signposting condition). This change happened during the transition between the internal pilot study and the efficacy study.

Table 4. Changes since the previous evaluation

	Feature	Pilot to efficacy stage
Intervention	Intervention content	No change.
	Delivery model	In addition to delivery in Wigan and Trafford, the intervention rapidly scaled up delivery to four new boroughs: Salford, Tameside, Manchester and Bolton.
	Intervention duration	The T3 visit only took place for those who consented to be involved in the project and evaluation prior to September 2023
Evaluation	Eligibility criteria	No change.
	Level of randomisation	No change.
	Outcomes and baseline	The T3 outcome measures were no longer administered.
	Signposting group	No change.

1.3   About the STEER programme

This section describes the STEER programme, including the STEER theory of change and who the programme works with.

1.3.1   The STEER theory of change

In line with the Early Intervention Foundation's 10 Steps for Evaluation Success, this section presents the STEER programme's theory of change. The theory of change was co-developed with STEER stakeholders, YEF representatives and Cordis Bright as part of the scoping phase of the internal pilot study. It did not change on the basis of the findings of the internal pilot study. The theory of change is presented in Table 5.

The theory of change shows that the STEER programme aims to achieve the following outcomes.

Short-term outcomes

- More children report that they have a trusted relationship with a positive role model.
- Children have an improved understanding of the risks and consequences associated with behaviours.
- Children have improved pro-social values and behaviours.
- Children have improved skills in emotional regulation.
- Children have coping mechanisms to disengage from contextual factors that may be encouraging serious violence and organised crime (such as factors operating in schools or with peers and families).
- Children have an improved understanding of and motivation for opportunities available to them (such as employment/training opportunities, education opportunities and opportunities in the community).
- Children have improved communication with parent(s)/carer(s).

Medium-term outcomes

- Children engage with more positive role models and have more positive, trusted relationships.
- Children demonstrate pro-social values and behaviours.
- Children have fewer contacts with the police.
- Children have improved engagement with training or employment opportunities (where appropriate).
- Children report improved aspirations around career, employment, future life, etc.
- Children report improved positive relationships with existing peers, associates and family members and/or a greater number of positive relationships with new peers and associates.
- Children report improved positive engagement with school (where appropriate) and other conventional societal interventions.

Long-term outcomes

Children report a reduction in or a reduction in involvement in :

- Violent criminal offences
- Organised crime
- Gang membership
- Non-violent offences

Table 5. Theory of change for the STEER programme

Why: evidence-based observation	Why: evidence-based need	Who: participants	How: intervention	What: outcomes		
				Short-term	Medium-term	Long-term
STEER has been developed to address: a) An increase in the number of children involved in serious youth violence, organised crime and gangs in Greater Manchester. b) An increased recognition among professionals of the complexity of issues displayed by children involved in serious youth violence, organised crime and gangs (e.g., the number of serious youth violence offences in Manchester increased by over 200% between 2016 and 2019; in the last three years, the number of knife crime offences in schools	Children's propensity for involvement in serious youth violence, organised crime, violence and gangs is increased by: a) Having close relationships with peers, associates and family members who are involved in serious violence, organised crime and gangs (Murray and Farrington, 2008) b) Having low levels of aspiration (Mahler et al., 2017) c) Risk-taking attitudes and behaviours (such as carrying weapons) (Boxford, 2006) d) Having poor emotional control (Salinas and Venta, 2021) e) Having low levels of pro-social values (Boxford, 2006) Mentoring has been shown to have a	Children aged 10–17 who are at risk of involvement in violent crime because they have an association with peers or family member(s) involved in serious violence, organised crime or gangs <u>and</u> who consent to participate in the programme. As part of this, children also have to meet one of the following criteria, which evidence shows are risk factors for serious violence, organised crimes and/or gangs. a) Experiencing violence in the family (Cordis Bright, 2015) b) Exhibiting overt coercion or violent	**A minimum dose of weekly one-hour sessions of one-to-one mentoring, coaching or casework** including the following mandatory topics: • Safety planning, • Relationship mapping • Understanding healthy relationships • Exploitation • Weapon carrying • Attitudes, behaviours and goal setting. Optional topics includes: • Cannabis use • Anger and aggression control • Family conflict • Educational support. In addition, there will be **another one hour of wraparound casework and support** (e.g. phone calls, online support, advocacy with other agencies and multi-agency meetings). **The weekly one-to-one sessions** include one-to-one activities and opportunities, as well as signposting and	An increased number of children report that they have trusted relationships with a positive role model. Children have an improved understanding of the risks and consequences associated with their behaviours. Children have improved pro-social values and behaviours. Children have improved skills in emotional regulation. Children have coping mechanisms to disengage from contextual factors that may be encouraging serious	Children engage with more positive role models and have more positive, trusted relationships. Children demonstrate pro-social values and behaviours. Children have fewer contacts with the police. Children have improved engagement with training or employment opportunities (where appropriate).	There is a reduction in: a) Violent criminal offences b) Organised crime c) Gang membership d) Non-violent offences

Why: evidence-based observation	Why: evidence-based need	Who: participants	How: intervention	What: outcomes		
				Short-term	Medium-term	Long-term
increased by 108%; and 22% of serious violence offenders in Greater Manchester were aged between 15 and 19) (Greater Manchester Serious Violence Action Plan, 2020; Gray, Smithson, and Jump, 2021). c) A recognition among local stakeholders that the available statutory responses on their own were not working effectively to reduce children's involvement in serious youth violence, organised crime and gangs in Greater Manchester. d) A belief among local stakeholders of the need to take an asset-based, trauma-informed	positive impact on the propensity to offend, especially if it is frequent and intensive (College of Policing, 2016). Having a mentor can reduce the likelihood of offending by providing a positive role model (College of Policing, 2016). Voluntary participation tailored to individual interests that take a trauma-informed approach encourages better engagement by children with services than statutory interventions for this cohort (National Lottery Fund, 2018). Providing parents and carers with the skills and understanding to manage risk factors and enhance protective factors can reduce involvement in	behaviour (Cordis Bright, 2015) c) Regularly carrying weapons, such as knives (Emmert, Hall, and Lizotte, 2018). d) Disengaging from mainstream education (Cordis Bright, 2015; Home Office, 2018; H.M. Government, 2018; H.M. Government, 2020). e) Missing from home or staying out unusually late or on a regular basis (H.M. Government, 2020). Children will not be eligible if they already receive interventions from multiple other services and/or have received	information-sharing. These sessions aim to give children access to a positive role model with whom they can identify and who can model positive behaviour. This is the key mechanism of change. As part of this, the mentors: • Help children understand the level and dynamics of risk associated with their behaviours • Provide sessions on social and emotional learning • Give children knowledge about how to understand and control their emotions • Give children knowledge of the implications for their lives of committing a crime • Encourage children to consider options for their future and support them in making informed, positive choices • Help children develop skills to sustain healthy, positive relationships • Give children strategies to disengage from contextual factors that might carry risk	violence and organised crime (such as factors in school, with peers and in families). Children have an improved understanding of and motivation for the opportunities available to them (such as employment/training opportunities, educational opportunities and opportunities in the community). Children have improved communication with parent(s)/carer(s).	Children report improved aspirations around career, employment, future life, etc. Children report improved positive relationships with existing peers, associates and family members and/or a greater number of positive relationships with new peers and associates. Children report improved positive	

Why: evidence-based observation	Why: evidence-based need	Who: participants	How: intervention	What: outcomes		
				Short-term	Medium-term	Long-term
approach with children on a voluntary basis, which may work more effectively to prevent involvement in serious youth violence, organised crime and gangs. e) A belief that progress for children in desisting from serious youth violence, organised gangs and crime is not a linear process (Phillips, 2017).	serious violence and gangs (Cordis Bright, 2015; H.M. Government, 2010; National Lottery Fund, 2018). Not all of the STEER cohort will live with their biological parents, and recent National Institute for Health and Care Excellence (NICE) guidance suggests that it is important that the care network around a looked-after child consists of positive relationships and that carers are provided with support services (NICE, 2021).	multiple custodial sentences.[6] Parents/carers of children will be offered support from family support workers. This will be aimed at the adult(s) who are most significant to the child's nurturing and flourishing. All children's most significant primary caregivers will be offered this support. Participation of adults in this support will be voluntary.	(such as spending time with peers engaging in criminal activity or peer pressure to miss school or stay out late)[7] • Encourage children to access positive activities that divert them from offending and from high-risk peers and associates **Family support worker (14 hours over six months) for families or caregivers of the STEER cohort:** • Improves parenting skills of parent(s)/carer(s) • Gives parent(s)/carer(s) strategies to manage boundaries with children • Gives parent(s)/carer(s) and children strategies to communicate more effectively with each other • Helps parent(s)/carer(s) interact more effectively with professionals		engagement with school (where appropriate) and other conventional societal interventions.	

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[6] This is because it is challenging operationally to deliver interventions when multiple other services are involved.
[7] The strategies used vary depending on the individual's circumstances and needs.

1.3.2 Who does STEER work with?

The STEER programme aimed to work with children aged 10–17 who are at risk of involvement in violent crime because they have an association with peers or family member(s) involved in serious violence, organised crime or gangs <u>and</u> who consent to participate in the programme. See Section 2.3 for more information about how participants are judged to be eligible for the programme.

1.3.3 How does STEER work with children and parents/carers to achieve its impact?

STEER is a documented intervention which uses a toolkit approach. The toolkit outlines the activities designed to achieve the programme's outcomes. The following summarises the key activities:

1. **Screening and referral.** Before entering the programme, children are referred by partners, including multi-agency panels in local authority areas, education, complex safeguarding teams, the police and youth justice teams, and they are screened by the STEER project manager. More information about this is presented in Section 2.3.

2. **STEER programme familiarisation and assessment planning.** Children allocated to the STEER programme receive initial interactions over four weeks, which allow STEER youth workers (mentors) to assess and build understanding of the child's strengths and needs. Youth workers use this time to carry out full risk assessments, using conversations to build a picture of the family context, supplemented by information shared between agencies. Co-design is a fundamental part of this process, taking on board the child's thoughts, ideas, hopes and concerns – in particular, to inform the optional and diversionary activities in the STEER toolkit (see point 3 below).

3. **Weekly one-hour, one-to-one mentoring sessions plus an additional one hour a week of wraparound support over a period of 24 weeks (six months) on average.** The child and their STEER youth worker agree on an individual action plan based on their needs/risk assessments. They then begin weekly one-to-one sessions, including one-to-one activities and opportunities, signposting, and information-sharing, plus an additional hour of wraparound support every week of the intervention (e.g. phone calls, online support, advocacy with other agencies and multi-agency meetings). This support aims to give children access to a positive role model with whom they can identify and who can model positive behaviour. The quality of the relationship between the STEER youth worker and child (mentee) is a key mechanism of change. As part of this, the mentor:

   o Helps the child understand the level and dynamics of risk associated with their behaviours

   o Provides sessions on social and emotional learning

   o Gives children knowledge about how to understand and control their emotions

   o Gives children knowledge of the implications for their lives of committing crimes

   o Encourages children to consider options for their future and supports them to make informed, positive choices

   o Helps children develop skills to sustain healthy, positive relationships

   o Gives children strategies to disengage from contextual factors that might carry risk (e.g. spending time with peers engaging in criminal activity or experiencing peer pressure to miss

school or stay out late). The strategies used vary depending on the individuals' circumstances and needs.

- o Encourages children to access positive activities that divert children from offending and from high-risk peers and associates

The face-to-face sessions use a toolkit of mandatory and optional topics.

Mandatory intervention topics include approximately three hours of work on each topic listed in Figure 1.

Figure 1. Mandatory intervention topics.

Safety planning	Relationship mapping	Understanding healthy relationships
Exploitation	Weapon carrying	Attitudes, behaviours and goal setting
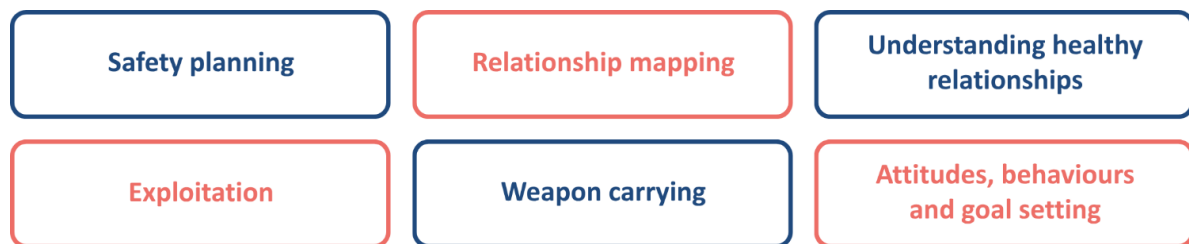
Additional/optional intervention topics. Children also have additional unit options, such as drug use, family relationships, emotional literacy and support, depending on their needs (including additional support) if progress in any of the above areas is slow. These sessions use a strengths-based approach to focus on developing the pro-social behaviours of children to build protective factors and reduce risk factors. This includes signposting and referral to mainstream providers to support diversionary activities. This is intended to help participants prepare for the end of the programme and build their capacity to take part in positive activities independently.

Fourteen hours of family support work spread across the duration of the six-month intervention. Recognising that children on STEER live in a wide variety of family and care-giving models, the STEER youth worker will help the child identify which adult or adults are most significant to their nurturing and flourishing. The family support will then be targeted at this individual or these individuals. In line with NICE guidance (2021), this support will also be offered to those undertaking care-giving roles for STEER children who are looked-after children (i.e. currently in the care of a local authority, including those placed with foster carers, in residential care or accommodated under Section 20), or care-experienced (i.e. previously looked after but no longer in care). The family support worker element aims to:

- Improve the parenting skills of the parent(s)/carer(s) of the participants.

- Give parent(s)/carer(s) strategies to manage boundaries with children.

- Give parent(s)/carer(s) and children strategies to communicate more effectively with each other.

- Help parent(s)/carer(s) interact more effectively with professionals.

1.3.4 How has STEER been designed to be sensitive to, and appropriate for, different groups?

The Salford Foundation designed STEER to be appropriate for children from diverse racial and ethnic backgrounds, ensuring that support is inclusive, accessible and culturally responsive. To ensure an inclusive approach was taken when delivering STEER, the following approach was embedded:

- **Diversity within the staff team.** This included some staff members who sit within different communities within Greater Manchester.

- **Mentee-to-mentor alignment.** When assigning mentors, the STEER team considered the ethnicity and gender of the mentors and, when capacity permitted, ensured the family's and child's preferences were met.

- **Equipping STEER mentors with the capability and opportunities to tailor session content from the Toolkit to meet the child's and the family's needs.** This included ethnicity and cultural adaptations (e.g. planning meetings around religious holidays) and consideration of special educational needs and disabilities (SEND) or neurodiversities (e.g. incorporating different activities to ensure engagement with and understanding of session content).

- **Commitment to learning about children's experiences, culture and religion.** Mentors were encouraged to have a good understanding of children's and their families' beliefs and boundaries and to share that knowledge within the team (e.g. respecting Muslim families' homes, and removing shoes). This included understanding the child's background (e.g. trauma) and being sensitive to their needs, including the language used during conversations.

- **Building trust by levelling out the power dynamic.** This includes showing respect to children by giving them a voice and choice from the outset and being able to modify content from the Toolkit to ensure children have a sense of autonomy during sessions and can feel a sense of trust with mentors.

- **Discussing social and structural factors of violence.** Conversations about violence go beyond individual choices to consider broader social and structural factors, ensuring discussions are relevant to the lived experiences of different communities.

- **Cross-organisational knowledge exchange.** This involves connecting with specialised organisations around cultural competency to share information both for mentors and the management team.

The STEER programme is trauma-informed, i.e., staff are trained in using trauma-informed approaches, and resources have been critically reviewed by the Salford Foundation to ensure they are trauma-informed. STEER's trauma-informed approach includes understanding how a child's previous trauma can impact or has impacted them, identifying and discussing triggers and challenges the child and their family have faced due to trauma, and ensuring children are not re-traumatised through the work.

1.3.5   What inputs are required to deliver STEER?

To deliver its intended activities and outcomes, STEER required the following inputs across the full delivery period (from May 2022 to March 2025):

- **Funding.** £998,066 across three years (£222,793 in year one, £391,924 in year two and £383,349 in year three). This included staff costs, equipment and materials, travel and expenses, additional expenses, and overheads. More information on funding can be found in Section 6.

- **Personnel.** The funding supported Salford Foundation staff's full-time equivalent roles across the three years, as highlighted in Table 6. Increases in staff numbers were necessary as STEER scaled up after the internal pilot study, going from delivery in two boroughs in Greater Manchester (Trafford and Wigan) to six boroughs (Manchester, Salford, Tameside, Trafford, Wigan and Bolton).

Table 6. Salford Foundation staff models for managing and delivering the STEER programme

Role	Pilot phase (Jan 22–Apr 23)	Efficacy phase (May 23–Mar 25)
Operations manager	0.4 FTE	0.4 FTE
Project manager	1 FTE	1 FTE
Mentors (youth workers)	2.6 FTE	6.6 FTE
Team leaders[8] (youth workers)	0	1.8 FTE
Referral and assessment coordinators	0.5 FTE (first quarter) then 1 FTE	2.0 FTE (first quarter) then 2.5 FTE
Family support worker	0.8 FTE	0.8 FTE[9]

FTE: full-time equivalent

- **Facilities.** This includes office space for workers at Salford Foundation House co-located with partner agencies, including youth justice services, Early Help Hubs and partner charity offices. Mentoring sessions took place at the location that is most appropriate for the child. This includes at home, at school, at Salford Foundation offices or in the community.

- **Workforce training and support.** STEER youth workers (i.e. mentors) are directly employed by the Salford Foundation. Workers who have proven experience in supporting children with complex needs, typically with a background in education, the voluntary sector or social care, are appointed. STEER youth workers complete comprehensive induction training before they commence work with children. This includes safeguarding, trauma-informed practice, trusted relationships, adverse childhood experiences, risk management and safety planning.

In addition to comprehensive induction training, workers have a weekly team meeting to discuss cases, good practice, etc. They have:

- Daily contact with their immediate colleagues and line manager.

- Formal performance reviews/management supervision on a six-weekly basis.

- Support from a psychologist in the Trusted Relationships team at North Pennine Mental Health Trust. The psychologist works in the team one day per week and provides case formulation and consultation, non-management supervision and bespoke training. [10]

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[8] Team leaders are mentors with additional management responsibilities.

[9] The Salford Foundation anticipated increasing this but based on the pilot phase findings, decided to replace it with additional mentor and referral and assessment coordinator capacity. The decision was taken that more family support worker capacity would have been unlikely to increase uptake.

[10] This support is paid for through the YEF grant, but the psychologist is not employed in the STEER team.

1.4 Evaluation objectives

1.4.1 Impact evaluation research questions

In line with the efficacy study protocol and the efficacy study statistical analysis plan (SAP), the overarching research question for the efficacy study was:

"Does a co-designed mentoring, coaching, family support and case management programme delivered to children (aged 10 to 17 years old) with known family members or peers involved in offending behaviour reduce the likelihood of participant involvement in serious youth violence and future offending or reoffending, in comparison to receiving business-as-usual (BAU) provision?"

To answer the research question, the primary long-term outcome measure was used to see whether there was a reduction in prevalence and variety of self-reported offending behaviours measured by the Self-Reported Delinquency Scale (SRDS; variety score) (Smith and McVie, 2003) for children receiving the STEER mentoring programme in comparison to those children receiving BAU.

To complement the primary research question and outcome measure, the evaluation also explored a number of secondary research questions and associated short-to-medium term outcome measures (which align with the theory of change). These included whether children receiving STEER in comparison to those in the signposting group receiving BAU:

- Demonstrate improved pro-social values and behaviours, measured by the Strengths and Difficulties Questionnaire (SDQ) pro-social behaviour subscale (Goodman, 2005)

- Demonstrate improved emotional symptoms, measured by the SDQ emotional symptoms subscale (Goodman, 2005)

- Demonstrate improved behaviours (e.g. aggressive or disruptive behaviour), measured by the SDQ conduct problems subscale (Goodman, 2005)

- Demonstrate improvements in their relationships with peers, associates and adult role models, measured by the SDQ peer relationships subscale (Goodman, 2005)

The quality of the mentor–mentee relationship was viewed as a key mechanism of change. This was measured using the Social Support and Rejection Scale (SSRS).

Additional efficacy study questions included:

1. **Delivery**: Can the STEER programme work under ideal circumstances?

2. **Impact**: a) What is the impact of STEER? b) For whom does STEER work, and under what conditions?

3. **Unintended consequences**: a) Does STEER have any unintentional consequences? If so, what are these? b) Do different groups of children experience these differently?

4. **Iatrogenic effects**: Are there any serious negative effects attributed to STEER on any intended or unintended outcomes?

5. **Mechanisms**: a) How does STEER work to reduce children's involvement in serious youth violence? b) Which factors contribute most to the observed outcomes?

1.4.2   Implementation and process evaluation research questions

The IPE was designed in line with YEF guidance on feasibility studies and IPEs and EEF guidance on IPEs. The primary objective of the IPE was:

- To understand the association between aspects of STEER's implementation and delivery and successful outcomes

- To gather data to support guidelines for the successful implementation of STEER

As such, key research questions are as follows:

1. Dimensions of implementation: How effectively has STEER been implemented?

- **1a. Fidelity.** To what extent has support been delivered in line with STEER's theory of change and toolkit?

- **1b. Dosage:** How many sessions have been delivered to children? How many sessions need to be delivered to have an impact?

- **1c. Quality:** How well has STEER been delivered?

- **1d. Reach:** How well has STEER reached its intended cohort?

- **1e. Responsiveness:** To what extent have children engaged with the intervention?

2. Factors affecting delivery and implementation: What are the key factors which influence the successful delivery and implementation of the STEER programme?

- **2a. Local area- / community-level factors:** Which factors have impacted implementation in local areas and communities, for example, level of need, availability of other services, system structures, existing referral pathways, readiness for change, and/or the policy practice and funding context?

- **2b. Organisation-level factors:** Which factors have impacted implementation at the organisational level, for example, capacity, skills and training, coordination, and resources?

- **2c. Unexpected factors:** Which other factors have had an impact?

3. Experiences of support: What are children's experiences of support?

- 3a. Which aspects of STEER have supported positive outcomes?

- 3b. How have children's experiences of support differed?

4. Guidelines for future implementation

- 4a. What are the implications for future replication, scale and spread?

1.5   Ethics and trial registration

Ethical approval

Ethical approval for the study was granted by The University of Greenwich Research Ethics Committee under reference UREC/21.3.7.4. This involved the submission of a detailed application, which was subject to review and scrutiny from the YEF and Salford Foundation colleagues. No delivery of the project or evaluation took place prior to ethical approval being obtained.

The RCT was registered on the International Standard Randomised Controlled Trial Number Registry website. The reference number is: ISRCTN 63663747.

More information about recruitment to the STEER programme efficacy study and collecting informed consent is summarised in Section 2.3.

Information sheets, consent forms and the privacy notice are presented in Appendices E and F.

1.6   Data protection

For this study, we (Cordis Bright, the evaluator) are the controllers of personal data throughout, as well as a processor of data, as specified in YEF data protection information and guidance for YEF evaluations. We have delivered the evaluation in line with our Data Protection and Information Governance Policy, which sets out our approach to storing and handling personal data for the evaluation.

We conducted a data protection impact assessment and developed a signed information sharing agreement with the Salford Foundation.

For this efficacy study, the processing of personal data is conducted under Article 6(1)(e) of the UK General Data Protection Regulation (GDPR), which permits processing for tasks in the public interest (i.e. conducting research and evaluating youth justice interventions).

Where special category data (e.g. ethnicity data) is processed, this is justified under Article 9(2)(j) of the UK GDPR, which allows processing for research purposes where safeguards (e.g. anonymisation or pseudonymisation) are in place.

This legal basis is appropriate because the evaluation aims to generate evidence that informs youth justice policy and practice, aligning with Cordis Bright's legitimate interest in conducting high-quality research and with the YEF's public-interest role of funding evidence-based interventions.

For this evaluation, we implemented:

- **A clear legal basis for sharing data with us**, e.g. public interest, public task, informed consent. To support data protection and follow GDPR requirements, we followed these processes, which were successfully trialled in the internal pilot study of STEER.

- **A robust process to transfer data**, i.e. the Salford Foundation transferred data using secure methods, such as secure email or Switch Egress. Monitoring data was obtained from the Salford Foundation's case management system. All questionnaires were completed anonymously using an anonymous ID number online (i.e. via Smart Survey) or a paper copy (back-up option). Only the evaluation team will have access to the responses.

- **Anonymisation and pseudo-anonymisation.** All participants were assigned unique ID numbers, and pseudonyms were used for interview transcripts. No personally identifiable information appears in any reports or publications. Only the minimum necessary personal data was collected and processed.

- **Informed consent.** Participants and family members were informed of their data protection rights through the information sheets and privacy notice administered as part of the onboarding session conducted by Salford Foundation referral and assessment coordinators. Service users accessing STEER consented to having their data shared with the evaluator. This consent is recorded in informed consent forms held by the STEER project and uploaded to their secure case management system. Paper copies of these forms are stored in a secure locked cabinet at the Salford Foundation premises and are destroyed by secure methods once they have been securely shared with Cordis Bright for their records. As part of this process, children and their families were made aware of their rights concerning how their data could be deleted if they requested it to be.

- **Secure storage of data.** Data was saved on Cordis Bright's secure cloud-based Microsoft 365 servers using the unique ID number. Personal or sensitive data has additional encryption, with access only to a designated or authorised member of the evaluation team. Participants were informed that all information about them was stored in this way (see Appendices E and F). Personal data was stored separately from questionnaire data.

- **Retention**. Once the final evaluation report has been signed off by the YEF, we will anonymise all data and hold it on the Cordis Bright server for six years after the final report is submitted to the YEF archive. We will securely delete the names and other personal data out of the datasets we hold after we give the data for data archiving, in line with YEF guidance.

1.7   Evaluation and STEER delivery teams

The evaluation of the STEER programme was led by Cordis Bright and took a collaborative approach, with input from the Salford Foundation and the YEF.

The STEER programme was designed by the Salford Foundation. During the set-up phase of the evaluation, Cordis Bright provided support to the programme through (a) supporting the refinement of the theory of change, (b) conducting an evidence review to support the refinement of the STEER toolkit and (c) supporting the redesign of the STEER referral form to support screening.

Delivery of STEER and the evaluation were funded by the YEF. There are no conflicting interests of which we are aware that may be perceived as influencing the design, conduct, analysis or reporting of the study.

Details of the key STEER delivery and Cordis Bright evaluation team members are presented below.

1.7.1   The Salford Foundation delivery team for STEER

- **Phil East (CEO, Salford Foundation)** was the senior relationship manager in charge of managing interactions between the Salford Foundation, the YEF and Cordis Bright. He was responsible for overarching implementation design and delivery with Greater Manchester public sector partners, including key partners such as the Violence Reduction Unit, the Deputy Mayor and GMCA, and reporting to strategic boards. He chairs the project's Strategic Steering Group, made up of senior multi-agency partners.

- **Sophie Sheehy (Operations Manager)** had overarching responsibility for project delivery and for the effective implementation of the evaluation from the Salford Foundation side. She led data sharing and the relationship with Greater Manchester Police data analysts, ensuring all processes were GDPR compliant. She was responsible for project learning and dissemination across Greater Manchester and beyond. She led the advance mobilisation plan into further local authority areas. She line-managed the Project Manager and had overall responsibility for budgetary control and reporting to the YEF. She had senior responsibility for safeguarding and risk management.

- **Jack Ward (Project Manager)** was responsible for the mobilisation of the project in each local authority area, including liaising with key public-sector partner managers. He was responsible for ensuring the project was set up and implemented with fidelity to the agreed model. He oversaw referrals, randomisation and caseload allocation and was responsible for management information, data entry and quality assurance. He was responsible for recruitment, induction, line management, supervision, training and support for mentors and family support workers. He was responsible for the further development and implementation of project resources, the toolkit and evaluation questionnaires.

- **Youth workers/mentors (including team leaders)** provided support to children in the STEER programme and were also responsible for the initial meetings and subsequent administration of outcome measure tools with the signposting group or children in the intervention group who were not subsequently allocated to them as a mentee. They ensured that the project tools, questions and methodology were implemented consistently and effectively. Mentors could support up to 13 children for six months. Team leaders could support up to 10 children for six months, accounting for line management time.

- **Referral and assessment coordinators** were responsible for the initial meetings, subsequent administration of outcome measures tools with children (in both the STEER and signposting groups), and the signposting and safeguarding check-ins at six months for children in the signposting group. They ensured that the project tools, questions and methodology were implemented consistently and effectively.

- **Family support workers** provided assistance and support to families of children on the programme, working with significant adult caregivers in the lives of the children. They aimed to provide 14 hours of support to parents/carers of children involved in STEER across the six-month STEER intervention timescale.

1.7.2 Evaluation team

- **Dr Stephen Boxford, Principal Investigator and Project Director,** ensured that the evaluation was delivered to a high standard by providing quality assurance throughout the project, including shaping the evaluation design, approaches, tools, analysis and outputs.

- **Professor Darrick Jolliffe, University College London, Co-Principal Investigator,** designed the evaluation, shaped approaches, designed tools, conducted analyses and ensured quality evaluation outputs.

- **Dr Jade Farrell, Co-Principal Investigator and Project Manager,** oversaw day-to-day project delivery and acted as the main point of contact for the YEF and the project delivery team. Jade took over this role following Suzie Clements' contributions to the initial phase of the evaluation.

- **Suzie Clements, Co-Principal Investigator and Project Manager,** played a key role in the early stages of the evaluation, overseeing initial project delivery and serving as the main point of contact for the YEF and the project delivery team.

- **Kam Kaur, Head of Safeguarding and Co-Principal Investigator,** provided expert input on safeguarding and consultation with children.

- **Emma Andersen, Senior Consultant,** provided analytical support and contributed to reporting.

- **Caitlin de Souza, Researcher,** provided ongoing support to STEER staff with administering the evaluation tools, conducting fieldwork, drafting the analysis, analysing quantitative data and supporting with report drafting.

- **Stella Butler, Researcher,** provided ongoing support for STEER prior to Caitlin joining the project team.

- **Madeleine Morrison, Researcher,** provided ongoing support for STEER during the internal pilot study and prior to Stella and Caitlin joining the project team.

- **Julie Ramambason, Researcher,** provided ongoing support for STEER during the internal pilot study and prior to Madeleine, Stella and Caitlin joining the project team.

1.8   Timeline

Figure 2 provides a detailed timeline of the study. Following the data collection for the internal pilot, there was a pause on new referrals into STEER. Referrals started again once the decision was made for the programme to progress to a full efficacy study.

Figure 2. Evaluation timeline

Delivery Timeline		Evaluation Timeline
	Jan 2022	Pilot study commenced
	Feb - Apr 2022	Toolkit reviewed and improved. Research tools finalised. Processes for randomisation, monitoring data, scripts and guidance finalised. Pilot study protocol completed. Ethical approval. Training for STEER practitioners.
Internal pilot study data collection began in two boroughs (Trafford, Wigan). Referral uptake fully integrated from October 2022. *Data collection and delivery of STEER continued.*	**May 2022 - Mar 2023**	
	Mar - Apr 2023	Pilot study IPE interviews with children (at six-months), staff and stakeholders.
	May - Jun 2023	Pilot study report completed.
Efficacy study data collection began. Salford Foundation accepted referrals again. Scale-up was rolled out in phases: Salford began in July 2023, followed by Manchester and Tameside in August 2023, and Bolton in May 2024. *All data collection and delivery for the efficacy trial ended 30th March 2025.*	**July 2023 - Mar 2025**	
	Nov 2024 - Feb 2025	Efficacy study IPE interviews with children (at six-months), staff and stakeholders.
	Apr - Nov 2025	Efficacy study analysis and report completed.

2   Impact evaluation methods

2.1   Trial design

The STEER efficacy study is a two-arm, parallel RCT. Delivery of the STEER programme for the purposes of this efficacy study started in May 2022 and finished in March 2025.

The efficacy study trial design is summarised in Table 7.

Table 7. Trial design summary

Trial design, including the number of arms		Two-arm parallel randomised controlled trial with random allocation at the child level
Unit of randomisation		Individual participant
Primary outcome	Variable	Reduction in the prevalence and variety of self-reported offending behaviours
	Measure (instrument, scale, source)	Self-Reported Delinquency Scale (SRDS) variety score
Secondary outcome(s)	Variable(s)	- Improved pro-social values and behaviours - Improved emotional symptoms - Improved behaviours - Positive relationships/role models
	Measure(s) (instrument, scale, source)	- Improved pro-social values and behaviours measured by the pro-social behaviour subscale in the Strengths and Difficulties Questionnaire (SDQ; Goodman, 2005) - Improved emotional symptoms measured by the SDQ emotional symptoms subscale (Goodman, 2005) - Improved behaviours measured by the SDQ conduct problems subscale (Goodman, 2005) - Positive relationships/role models measured by the peer relationships problem subscale in the SDQ (Goodman, 2005)
Baseline for primary outcome	Variable	Reduction in the prevalence and variety of self-reported offending behaviours
	Measure (instrument, scale, source)	SRDS variety score
Baseline for secondary outcome(s)	Variable	- Improved pro-social values and behaviours - Improved emotional symptoms - Improved behaviours - Positive relationships/role models
	Measure (instrument, scale, source)	- Improved pro-social values and behaviours measured by the SDQ pro-social values subscale (Goodman, 2005) - Improved emotional symptoms measured by the SDQ emotional symptoms subscale (Goodman, 2005)

Trial design, including the number of arms	Two-arm parallel randomised controlled trial with random allocation at the child level
		- Improved behaviours measured by the SDQ conduct problems subscale (Goodman, 2005) - Positive relationships/role models measured by the SDQ peer relationships problem subscale (Goodman, 2005)

No important changes have been made to the efficacy study design since the internal pilot study report and the efficacy study protocol.

2.2   Overview of participant journey

Figure 3 summarises the participant flow diagram for the efficacy study. It summarises the following key steps:

- The referral and screening process
- The collection of informed consent from parents/carers and children
- Data collection at baseline (time 1; T1) and follow-up (time 2; T2)
- Randomisation processes
- Delivery

The rest of this section describes how each of these processes was implemented during the efficacy study.

Figure 3. Efficacy study RCT design

Key:
- Green = consent
- Red = no consent/attrition
- Orange = treatment group
- Blue = control group
- Pink = evaluation activity

Referrals from a range of agencies, mainly children's social care and Greater Manchester Police. Referring partners ask for consent from child before referral is made → Consent not given
↓ ↓
Consent for referral confirmed No further contact
↓
Local multi-agency partnership board meeting to discuss the referral process and monitor the project; screening tools used to direct referrals ↑
↓
Information gathering by STEER colleagues from partner agencies Consent from child or child not given
↓ ↑
Consent from child or parent/carer not given ← Meeting 1 between coordinator, child and parent/carer at the most appropriate venue to introduce project, evaluation, data archive and gain consent → Visit with child and parent/carer isn't present → Informed and written consent from child confirmed
↓ ↓ ↓
No further contact Informed and written consent from child and parent/carer confirmed ← Second visit with parent/carer ← ←
↓
Meeting 2 to administer SDQ and SRDS Consent from parent/carer not given → No further contact
↓
Treatment – receive a start date for STEER ← **Randomisation** → **Control** – Signposted to other agencies to receive mainstream support
↓ ↓
'Get to know you stage', and plan created Difference in baseline need between treatment and control assessed to ensure comparability Doesn't receive STEER
↓ ↓
Children and families receive support from STEER STEER maintains light-touch contact at 6 months (including catch up, assessment of need, signposting to services and safeguarding)
↓ ↓
Does not complete the support package ← Characteristics of attrition identified ← Complete the support package
↓ ↓ ↓ ↓
Dosage monitored. As a minimum yes/no to different elements Dosage and content of sessions monitored by STEER (as a minimum, yes/no to different elements) Dosage monitored (contact with STEER and referrals to signposting). As a minimum yes/no to different elements
↓ ↓ ↓ ↓
Questionnaire (including SSRS) administered at exit (6 months) Differences between the dosage of support assessed Questionnaire (including SSRS) administered at exit (6 months) Differences in impact and dosage between treatment and control assessed at baseline and 6 months Questionnaire (including SSRS) administered at 6 months

SDQ: Strengths and Difficulties Questionnaire. SRDS: Self-Reported Deliquency Scale. SSRS: Social Support and Rejection Scale.

2.3   Participant selection

Eligibility criteria

The target group for the STEER programme and, therefore, the efficacy RCT were children aged 10–17 who are at risk of involvement in violent crime because they have an association with peers or family member(s) involved in serious violence, organised crime or gangs and who consent to participate in the programme.

Children <u>also</u> needed to meet one of the following criteria, which evidence suggests are risk factors for involvement in serious violence, organised crime and/or gangs (more information about how these were assessed is in the section on the referral and screening process below):

- Experiencing violence in the family (Cordis Bright, 2015)

- Exhibiting overt coercion or violent behaviour (Cordis Bright, 2015)

- Regularly carrying weapons, such as knives (Emmert, Hall, and Lizotte, 2018)

- Disengaging from mainstream education (Cordis Bright, 2015; H.M. Government, 2018; H.M. Government, 2020; Home Office, 2018)

- Missing from home or staying out unusually late or on a regular basis (H.M. Government, 2020)

Children were not eligible for participation in STEER or the research if they had already received interventions from multiple other services and/or had received multiple custodial sentences. This was because if a child is receiving interventions from multiple other services, it would be more challenging to attribute any impact to STEER alone. There is also a risk that the child and their family could be overwhelmed by professional input, which might lead to disengagement.

STEER did not work with children who had received multiple custodial sentences because the project aimed to intervene at an earlier stage of criminal activity to prevent children from entering the criminal justice system. All children's most significant primary caregivers (i.e. those who are most significant to the child's nurturing and flourishing) were to be offered family support. This offer was open to any caregivers in the child's life and was not restricted to a specific number of caregivers.

These eligibility criteria were based on evidence of risk-protective factors from existing research and were researched and agreed upon by the Salford Foundation, Cordis Bright and the YEF.

Referral and screening process

Referral partners identified children with risk factors in line with STEER's eligibility criteria and referred them into the STEER programme. The STEER project manager reviewed all referrals against the STEER screening tool (which was co-developed by the Salford Foundation and Cordis Bright and was implemented before the start of the internal pilot study) to identify which children were eligible for STEER. The STEER team gathered information about the child from partner agencies to inform this screening process. This process provided confidence that all children in this efficacy study were eligible for participation in STEER.

STEER staff also attended multi-agency panels to identify children who might be suitable for STEER. In all areas it operated, STEER staff attended the Prevention, Intervention, Education and Diversion (PIED; also

referred to as Engage in Manchester)[11] multi-agency panel to identify and screen referrals. These panels included representatives from education, complex safeguarding teams, the police and the youth justice team. Examples of additional multi-agency meetings/networks that supported referral processes included:

- Earliest Help Weekly Drop In (Wigan)

- Trafford Team Together

- Trafford Youth Network

- AFRUCA Network for Exploitation (Manchester)

- Operations Meeting for Children and Young People Missing from Home and those subject to Exploitation (Complex Safeguarding)

- Antisocial behaviour over summer planning meetings

- Healthy Schools Provider Forum

STEER staff reported that key referral partners included youth justice teams, education, complex safeguarding, Greater Manchester Police and GMCA. The referral partner gained verbal consent from the child and their parent/carer to make a referral to STEER.

Recruitment and the collection of informed consent

If a child was identified as eligible for STEER, a STEER practitioner (STEER referral and assessment coordinator) arranged a meeting with the child and their parent/carer at the most appropriate venue (e.g. at school, at home or in the community). The aim was for this meeting to occur within one week of the initial referral. During this meeting, the STEER practitioner:

- Explained the research and the project to the child and their parent(s)/carer(s) using a script co-developed between Cordis Bright and STEER practitioners. Cordis Bright also provided training to STEER practitioners to support them in recruiting children into the efficacy study.

- Gave the child and their parent(s)/carer(s) a participant information sheet and privacy notice, clarifying any issues that were not clear and reading out the information if required.

- Gave the child and parent(s)/carer(s) the consent form to read and sign (the practitioner read out the consent form if required)

These processes adhered to good practice guidelines, including Data protection information for YEF evaluations and the Government Social Research Unit's Ethical Assurance for Social and Behavioural Research guidance, to ensure they are accessible, inclusive and culturally sensitive.

Data collection and locations

After they had collected consent, STEER practitioners administered the baseline tools (T1) before randomisation and administered the six-month follow-up measures (T2) at the location where the

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[11] In some areas, this is referred to as PPIED (Prevention through Prosecution, Intervention, Education and Diversion).

intervention normally took place, i.e., at school, at home, in the community or at the Salford Foundation offices.

The trusting relationships that STEER practitioners developed with children were critical in ensuring a good response to the questionnaires. Our approach helped to ensure that children were not influenced by STEER practitioners when completing questionnaires through the following mechanisms:

- We co-developed a STEER practitioner evaluation handbook and provided training, which outlined dos and don'ts concerning questionnaire administration to help ensure children completed the questionnaires independently.

- The questionnaires were administered online, and each child completed them on a tablet.[12] As part of the co-developed evaluation handbook and through practitioner training, we asked practitioners not to look at the responses children were providing.

2.4   Equity, diversity and inclusion

We worked hard to ensure our approach considered and promoted equity, diversity and inclusion (EDI). As such, we committed to delivering the evaluation in line with EDI. Government statistics indicate that minority ethnic groups are overrepresented throughout the criminal justice system; for instance, in 2020, a higher proportion of prosecutions against children were for Black (12%) and Mixed ethnic (14%) groups than for White (5%) defendants (Ministry of Justice, 2021). This was key to this study because the STEER programme aims to address risk factors and strengthen preventative factors associated with offending behaviour, with the aim of reducing the likelihood of children's (including those from minority ethnic backgrounds) involvement with the criminal justice system.

All of Cordis Bright's evaluation work is delivered in line with our EDI strategy (available here) and EDI project toolkit (available here). This sets out our commitment, principles and approaches to ensure that our work is accessible to all. We commit to:

- Providing equal opportunities in all aspects of employment and ensuring that we do not discriminate in recruitment or employment on the basis of a protected characteristic or any other characteristics or identities

- Opposing discrimination in all its forms, be it at a structural, institutional or inter-personal level, including direct discrimination, indirect discrimination, discrimination by association, discrimination by perception, victimisation, harassment and bullying

- Seeking to build our understanding of the barriers created by discrimination and inequality and ensuring fair, equal and inclusive treatment for our staff, clients and the people whom our work aims to support

In line with these commitments, to ensure EDI in this efficacy study, we:

- Provided clear, accessible information so that participants from all communities could participate.

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[12] Where young people could not complete the questionnaire on a tablet (e.g. when access to wi-fi was limited), they were able to complete paper copies of the questionnaire.

- Used informed consent processes and materials that adhere to good practice guidelines, including the YEF's and the Government Social Research Unit's, to ensure they were accessible, inclusive and culturally sensitive.

- Monitored key demographic and socioeconomic information of all participants in the STEER and signposting groups to enable us to analyse any differences in recruitment and retention across different groups and to assess whether they are representative of similar cohorts in the youth justice system and wider society.

- Deployed staff who had completed cultural competency training as well as undertaken projects on equality and inclusion, including over-representation of children from minoritised ethnic groups in the youth justice system.

- Conducted exploratory subgroup analyses of differences in the primary outcome achieved by different ethnic groups, i.e. between ethnic categories of White and minority ethnic groups – we had to collapse Office of National Statistics ethnicity groups for the purposes of sample size.

- Worked with the Salford Foundation to ensure that a broadly representative sample of children who participated in STEER was interviewed as part of the IPE – see Table 24, which shows the demographic breakdown of the children we interviewed.

- Ensured that all members of our evaluation team were experienced at working with minoritised and marginalised communities. As part of our commitment to continuous improvement, we discussed and reflected with Salford Foundation and YEF colleagues on the most effective ways to conduct research and evaluation in as equitable, inclusive and accessible a way as possible.

2.5   Randomisation approach

The process for randomisation used in the efficacy study was in line with the STEER internal pilot study report and efficacy study protocol. This process followed good practices set out in Nesta guidance (Edovald and Firpo, 2016).

All children who were referred to the programme, met the eligibility criteria, consented to be part of the evaluation and completed a baseline questionnaire were allocated at random to the STEER or signposting group on a one-to-one basis, as per Hutchison and Styles (2010).[13]

A one-to-one randomisation approach means that the STEER and signposting groups are of similar size (achieving as close to a one-to-one ratio as possible). This approach was taken as it was deemed the simplest to implement practically, plus it is the most efficient from a statistical perspective since it requires the fewest number of treatment group participants to achieve a given level of statistical power (Hutchinson and Styles, 2010).

Randomisation was conducted using randomly varying blocks of four, six and eight children, in which the numbers of children allocated to the STEER and signposting group were the same. These block sizes were

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[13] It is possible that some siblings were referred as individual cases and, therefore, randomised independently. However, while the eligibility criteria included young people with family or peer associations linked to serious violence or organised crime, referrals were based on individual risk and consent, not on family or household membership. Any overlap between siblings is, therefore, likely to have been minimal, and any resulting non-independence negligible.

selected, as they were small enough to maintain balance between groups throughout the trial while being large enough to reduce the predictability of allocation and minimise potential bias. Randomly varying block sizes were used to further reduce the likelihood that practitioners would be able to predict allocation. See Nesta guidance for more information (Edovald and Firpo, 2016).

The process followed a randomisation sequence that was digitally generated by Cordis Bright. Generating the randomisation sequence digitally rather than manually means that the integrity of the process is more likely to remain intact, it is easier to implement and there is a clear audit trail (Dettori, 2010). This limits the opportunity for interference in the process and means that the evaluation team can audit and monitor the randomisation approach.

Envelopes were prepared for each child, each with an evaluation reference number on the front and an allocation slip inside, indicating which group the child had been assigned to. This matched the digital random allocation sequence. Envelopes were prepared using the sequentially numbered, opaque, sealed envelopes method, using carbon paper to ensure that the allocation slip was concealed.

These envelopes were couriered to Salford Foundation Offices and stored in a locked cupboard. Children were allocated an evaluation reference number by the project manager at the time of referral. Children received an introductory visit, during which T1 questionnaires were completed after informed consent was gained. After this visit, randomisation envelopes were opened by the STEER project manager at the Salford Foundation offices, and the result was communicated to children and parents/carers by phone.[14]

STEER practitioners were given training and an evaluation handbook and had access to continuing support from Cordis Bright on how to implement this process, as well as on how to communicate the randomisation result to the child and their parents/carers so as to avoid the feeling of winning or losing, depending on the outcome.

No blinding of allocation was possible in this process. STEER practitioners who acted as data collectors needed to be aware of which group the child had been allocated to so they could administer support accordingly. Children were informed of what the STEER and signposting groups entailed so they could give their informed consent.

2.6   Business-as-usual

Those in the treatment group received the STEER programme. Those in the signposting control group attended a meeting with a STEER referral and assessment coordinator after randomisation, where they received signposting to existing services and had any safeguarding needs identified and addressed. Children in the signposting group received appropriate support, which would normally be offered under BAU (i.e. support that they would have likely received anyway without STEER being present).[15] As part of the evaluation, those in the signposting group received this signposting support again at around six months (i.e.

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[14] During May 2022 to July 2022, a slightly different process was implemented, which included young people receiving two introductory sessions: the first to gain consent, the second to complete T1 questionnaires and activate the randomisation approach. This change further streamlined the process. More information on this can be found in the pilot internal report.

[15] The extent of BAU support accessed by young people in either the signposting (control) or STEER (intervention) group was not captured or quantified during the RCT, which may help explain similar gains across groups.

similar to the length of the intervention), at which time they also completed a follow-up (T2) outcomes measures questionnaire. The STEER referral and assessment coordinator assessed their needs, signposted the child to existing services and identified any safeguarding concerns.

If any safeguarding needs were identified during either of these meetings, the STEER referral and assessment coordinator would refer them to the relevant authorities.

2.7 Outcomes measures

Table 8 maps the outcomes from STEER's theory of change against the validated measures which were used to capture them. Both the outcomes and measures were discussed, prioritised and agreed upon in discussions between Cordis Bright, the Salford Foundation and the YEF.[16]

Questionnaires included the YEF core measures:

- SRDS

- SDQ

In addition, at follow-up (T2), to test the quality of the mentor–mentee relationships, we included:

- SSRS

All measures were reviewed prior to the internal pilot study to ensure they were in line with Early Intervention Foundation evidence standards, i.e. that they are not amended, that they are standardised and validated, and that they capture the project outcomes. In addition, measures which are brief, use clear and age-appropriate language, and have been validated for use with children of the same age were prioritised.

Table 8. Outcomes measures

Outcome from the theory of change	Measure	Subscale(s)	Items	Time point(s)
Primary outcomes measure (long-term outcome)				
Reduction in prevalence and variety of self-reported offending behaviours	SRDS	Variety score	19	Baseline (T1); six months (T2).
Secondary outcomes measures (short-to-medium term outcomes)				
Improved pro-social values and behaviours	SDQ	Pro-social behaviour subscale	5	Baseline (T1); six months (T2).
Improved emotional symptoms	SDQ	Emotional symptoms subscale	5	Baseline (T1); six months (T2).
Improved behaviours	SDQ	Conduct problems subscale	5	Baseline (T1); six months (T2).
Positive relationships/role models	SDQ	Peer relationships problem subscale	5	Baseline (T1); six months (T2).
Mechanism of change				

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[16] Outcomes in the theory of change around increased understanding, coping mechanisms, training/employment opportunities, career/employment aspirations and engagement with school were not prioritised for measurement during the evaluation design and set-up. We have presented evidence in relation to some of these in the IPE.

Outcome from the theory of change	Measure	Subscale(s)	Items	Time point(s)
Positive relationship between a child and their mentor (STEER) or a child and a significant adult (signposting)	SSRS	Full measure	22	Six months (T2).
SDQ: Strengths and Difficulties Questionnaire; SRDS: Self-Reported Delinquency Scale; SSRS: Social Support and Rejection Scale				

Outcomes were measured at the individual level through the administration of online, self-reported, validated measures. Self-report data were collected with support from STEER practitioners at home, at school, in the community or at Salford Foundation offices. Data was collected at two time points:

- **Baseline (T1),** once informed consent has been achieved from parents/carers and children, prior to randomisation and before support from STEER began for those in the treatment group

- **Six months (T2),** for both the treatment (on exit from the programme) and signposting groups (at approximately six months, i.e. mirroring the length of the STEER intervention)

2.7.1 Primary outcome

The primary outcome for the evaluation of STEER is a reduction in the prevalence and variety of self-reported offending behaviours between baseline and six months. This was measured by the SRDS, as highlighted in Table 8. The primary outcome time point is T2, i.e. six months after randomisation or at the end of support from STEER. The efficacy study explores the impact of STEER in comparison to the signposting group on the SRDS variety score, which measures the number of different offending behaviours that the child has been involved in.

The SRDS variety score was chosen over the volume score because:

- Evidence shows that there is a strong correlation between the prevalence/variety of offending and the frequency/volume of offending (Monahan and Piquero, 2009).

- Statistically, the volume score may be less accurate, as it asks children to report the number range of incidents rather than a specific number.

- The questionnaire structure means that volume data is collected after variety – this increases the risk of reporting error and the potential for testing effects.

On this basis, we considered that the use of the SRDS variety score was the most statistically and theoretically sound measure for use in this study.

About the Self-Reported Delinquency Scale variety score

The SRDS is a 19-item scale developed as part of the Edinburgh Study of Youth Transitions and Crime (Smith and McVie, 2003). It covers a range of antisocial and offending behaviours, has been validated for use with children in the UK and has been used with those aged between 10 and 17. The variety score is the sum of the number of times that a child has reported Yes across 19 different items (it is a score of 0–19).

The SRDS has been shown to have good psychometric properties; reported internal consistency is 0.87–0.92, with an inter-item correlation of 0.19 (Fonagy et al., 2018; Humayun et al., 2017), and the measure correlates with official police arrests (89.5–95.2%; McAra and McVie, 2005). More information on the

2.7.2   Secondary outcomes

The secondary outcomes that we are investigating are whether children receiving STEER have:

- Improved pro-social values and behaviours
- Improved emotional symptoms
- Improved behaviours
- Positive relationships/role models

See Table 8 for information on how these outcomes will be measured using subscales from the SDQ. For all measures, the secondary outcome time point is T2, i.e. approximately six months post-randomisation. These measures were selected in agreement between the Salford Foundation, the YEF and Cordis Bright.

About the Strengths and Difficulties Questionnaire

The full SDQ is a 25-item questionnaire measuring behaviours, emotions and relationships for 4- to 17-year-olds. It contains five subscales with five items in each:

1. Emotional symptoms
2. Conduct problems
3. Hyperactivity/inattention
4. Peer problems
5. Pro-social behaviours

Each item is scored on a 3-point Likert scale from 0 to 2, such that the scores for each subscale range from 0 to 10. For the pro-social values subscale, high scores are desirable (i.e. greater pro-social values), but for the conduct problems subscales, high scores are not desirable (i.e. greater conduct problems). The SDQ has been shown to have good internal consistency (Cronbach's alpha = 0.73), cross-informant correlation (mean = 0.34) and retest stability after four to six months (mean = 0.62; Goodman, 2001). The YEF aims for common outcomes measures to be used where possible to maximise learning, and the SDQ has been endorsed for measuring behaviours, emotions and relationships. Previous research has found that the SDQ correlates with the level of offending in young offenders (van Domburgh et al., 2011).

2.7.3   Mechanism of change

We also used the SSRS to measure the quality of the relationships between children and trusted adults[17] (signposting group) or mentors (STEER group) at six months (T2).

About the Social Support and Rejection Scale

The SSRS has four dimensions: Feels valued, Trust, Mentoring, and Negativity. Each item is scored from 1 (never) to 5 (always). Each subscale score is the average of the 22 items that make up the subscale. Higher

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[17] Young people in the signposting group were only prompted to complete the SSRS after confirming that they had a trusted adult in their lives.

scores on the negativity scale reflect higher levels of stress and negativity within the relationship. For the overall scoring of the scale, a high score represents a positive relationship.

The SSRS was selected since this relationship with a mentor was hypothesised to be a key mechanism of change in the STEER project (as highlighted in the STEER theory of change). The length and the quality of the relationship that develops between children and their mentors are considered the central avenue through which mentoring can benefit (or, in some instances, inadvertently harm) children (Karcher and Nakkula, 2010). The SSRS was selected following a review of scales measuring mentorship relationship quality conducted by Cordis Bright and was agreed with the Salford Foundation and the YEF before proceeding.

2.7.4 Outcomes measure data collection

STEER practitioners administered the questionnaires because the trusting relationships they developed with the children were considered by the Salford Foundation, the YEF and Cordis Bright colleagues to be critical in encouraging the completion of the questionnaires. This was also a more practical approach for the intervention group, i.e. T2 questionnaires could be administered as part of usual meetings, and the children would feel comfortable in asking for clarification on questions if needed – and their mentors would understand how to communicate this to them effectively.

At baseline, children completed the questionnaire prior to finding out whether they were in the STEER or signposting group.

We employed the following mechanisms to ensure that children were not influenced by STEER practitioners when completing questionnaires:

- The questionnaires were online, and each child completed them on a tablet. As part of the co-developed evaluation handbook and during practitioner training, we asked practitioners not to look at the responses the children were providing.
- We co-developed a practitioner evaluation handbook and provided training, which outlined dos and don'ts concerning questionnaire administration to help ensure children completed the questionnaires independently. This included:
  - o Providing practitioners with example scripts to introduce the questionnaires, as well as examples of how to respond to children in situations, so as not to influence questionnaire completion.
  - o Encouraging practitioners to be guided by the children's needs, for example:
    - Give the child the space and time to complete the questionnaire. For example, if a child gets distressed while completing a questionnaire, work with them to calm them and then ask them to continue. However, there was an understanding that the children's welfare comes first, so practitioners should use their professional judgement.
    - Read out questions word-for-word to the child, if this will help them.
    - Explain what a word means if the child is unsure.
    - Make sure the child is engaging with the questions, i.e. encourage them to complete the questionnaire properly and to the best of their ability.
    - Don't chang the wording of the questions unless absolutely necessary when helping a child, for example, if the child is struggling to understand certain terms.

All outcomes data were scored by Cordis Bright (more information on data handling and analysis in Section 2.9).

2.7.5 Monitoring and activity data

The Salford Foundation was responsible for collecting monitoring data using their existing client relationship management system. Cordis Bright provided support on what data would be required and worked with Salford Foundation colleagues and the client relationship management system software providers to support the process during the evaluation setup, data collection for the internal pilot and following the delivery of the internal pilot study report. A decision was made not to design and implement a bespoke monitoring system for the trial. This was because it would have included duplication, required additional resources and increased the burden on Salford Foundation staff. The Salford Foundation had an existing client relationship management system, which the evaluation aimed to use as effectively as possible.

This efficacy study has been informed by the following monitoring data provided by the STEER team:

- **Flow through the programme** for all children who were referred to STEER (including numbers of referrals, accepted as eligible, consented, not consented, started, completed or dropped out).

- **Background characteristics** for all children who consented to be involved in the evaluation (including accommodation type, current borough of residence, children's services involvement, age, ethnicity, gender, physical disability, SEND, looked-after child and primary language).

- **Activity data, including:**

    o Duration of support for children in the treatment group (dates started and ended and points in between)
    o Quantity of support for children in the treatment group (number of sessions received)

Following the internal pilot study, we identified some areas for improvement in how monitoring and activity data was recorded. We worked with STEER staff to address these areas and to improve the consistency and completeness of monitoring data recording. This included working with colleagues on:

- The importance of recording monitoring information in an accurate, complete and timely manner
- Ensuring that all activities delivered are recorded against a support area (i.e. a topic or theme of support)
- Linking specific activities in the monitoring data with times to reduce the burden of data collection and increase consistency of recording dosage
- Reviewing the metrics collected to ensure that only those relevant to the evaluation or project delivery were being collected and to reduce duplication of data

We worked with the STEER project manager to plan and organise training for STEER staff around these topics, which we delivered on a training day in Autumn 2023.

2.8 Sample size

This section sets out the sample size calculations for the STEER RCT. It discusses our:

- *A priori* power calculation, conducted at the protocol stage
- Post-randomisation power calculation, conducted once all baseline data had been collected

2.8.1 *A priori* power calculation

At the time of design, the YEF's standard power guidance recommended trials be powered to detect moderate effects (Minimum Detectable Effect Size [MDES] ≈ 0.20). The trial was therefore designed appropriately under this framework, rather than to detect smaller effects, which would have required a substantially larger sample. Our original power analysis suggested that a total sample of 654 children (327 per group) across the internal pilot study and efficacy study would allow a statistically significant result to be identified (power = 0.80, two-tailed $p<0.05$) for an 11% reduction in involvement in offending.

Our original approach was conservative and in line with Lipsey and Wilson (2001), who state that ½d = r, which is, in turn, equivalent to the difference in proportions. Table 9 shows that if we suggest that 30% of the children who STEER does not work with commit violence, compared to 20.5% of the children who STEER does work with committing violence (equivalent to a Cohen's d = 0.19), a total sample of 654 (327 in each group) would be needed to detect a statistically significant result (power = 0.80, two-tailed $p<0.05$). This level of Cohen's d was selected because it is conservative and is about equivalent to a 10–11% difference, which is in line with a weighted average effect size of mentoring programmes based on comparisons of 18 studies in a meta-analysis of mentoring and offending using a random effects model (d = 0.21, 95% CI: 0.07 to 0.34) presented by Jolliffe and Farrington (2008).[18]

Table 9 presents the results of our power analysis at the protocol stage. It shows that in line with our conservative approach, we used a pre-test/post-test correlation of 0. This is because it was difficult to estimate what the pre-test/post-test correlation would be, as this depended on unknown sample characteristics and the characteristics of the measure under investigation (the SRDS when used in a sample similar to STEER, i.e. those who are known to have peers or family members involved in offending behaviour). Having the pre-test/post-test correlation set at 0 meant that we had more of a buffer to detect a significant impact if it exists, if STEER did not recruit the numbers anticipated or if questionnaires were spoiled.

SPSS 25 was used for these power calculations.

2.8.2 Post-randomisation power calculation

In line with good practice, we then repeated our power analysis based on our final sample once all randomisation had been completed. This power analysis was based on the numbers involved in the RCT at baseline. This is also presented in Table 9. As part of this calculation, we included a pre-test/post-test correlation of 0.5. This is based on values obtained from unpublished data from an RCT using the same outcomes measure conducted with a similar population of adolescents (Humayun et al., 2019), which we discovered after our original power analysis at the protocol stage.

In this analysis, the SRDS variety score was treated as a continuous variable for pragmatic reasons. While the SRDS is a count variable (ranging from 0 to 19), its distribution and range make it suitable for approximation as continuous in power estimations. In practice, treating the SRDS variety score as continuous in power estimation is unlikely to materially affect the validity of the results. Based on this approach, our

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[18] This rapid evidence assessment found mentoring was more effective in reducing reoffending when contact between mentor and mentee was greater, in smaller scale studies, and when mentoring was combined with other services and interventions.

power analysis yielded an MDES of 0.186 based on baseline data collection, almost the same as the original protocol calculation (0.19).

PowerUp! (Dong and Maynard, 2013) was used for the calculations once all randomisation and baseline data collection were completed.

Table 9. Sample size calculations

		Protocol	Randomisation
Minimum Detectable Effect Size		0.19	0.186
Pre-test/post-test correlations	Level 1 (participant)	0.0	0.5
	Level 2 (cluster)	N/A	N/A
Alpha		0.05	0.05
Power		0.8	0.8
One-sided or two-sided?		Two-sided	Two-sided
Number of participants by the end of the randomised controlled trial	Intervention (STEER)	327	337
	Control (signposting)	327	352
	Total	654	689

2.9 Approach to statistical analysis

2.9.1 Overview

All analyses were done on an intention-to-treat (ITT) basis. This means that all participants were analysed according to their initial treatment allocation, regardless of whether they received STEER. This is in line with YEF analysis guidance and our efficacy study SAP. All analyses were conducted in SPSS version 28.0.

2.9.2 Primary analysis

The primary outcome for the RCT was the SRDS variety score. For the primary analysis, we conducted complete case analysis (CCA) using an ITT approach, i.e. all children with valid scores for the SRDS variety score at T1 and T2 were included in the analysis, in line with their original allocation. For the SRDS variety score, scores were pro-rated[19] for children who had completed at least 60% of the scale, i.e. completed 12 out of 19 items. This approach helps to maximise available data while maintaining the reliability of the outcome measure. More about the SRDS variety score and how it is calculated is presented in Section 2.7.

We used a generalised linear model to estimate the treatment effect of receiving STEER on the SRDS variety score at T2, controlling for baseline scores. This model included two covariates:

- The SRDS variety score at T1 to account for participants' starting points

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[19] Pro-rating a scale means calculating a participant's score when they have completed most, but not all, items on that scale. For example, if a child completed 12 out of 19 questions, this would involve calculating their average score across the 12 completed items and multiplying this by 19 to estimate their total score.

- Treatment allocation, i.e. whether the participant was in the STEER intervention group or the signposting control group

As the SRDS variety score is a count variable (e.g. how many different types of offences a participant was involved in), we initially considered using a Poisson regression model, which is commonly used for count data. However, we found that the data had more variability than a Poisson model can handle (in technical terms, the variance was greater than the mean, with the variance = 8.36 and the mean = 3.40). To address this, we used a negative binomial regression, which is a more flexible (generalised) version of the Poisson regression model. It includes an extra parameter to account for the extra variability not captured by a Poisson model. Please note that this approach is a deviation from our study protocol and statistical analysis plan.

The model we used for our primary analysis was:

$$log(\mu_i) = \beta_0 + \beta_1(SRDS, T1_i) + \beta_2 (Group_i)$$

Where:

- μ_i is the expected count of the SRDS variety score at Time 2 for participant i.
- β_0 is the intercept term.
- β_1 is the coefficient for the baseline SRDS variety score at T1 for participant i.
- $Group_i$ is a dummy variable for treatment allocation, coded 1 for participants in the STEER group and 0 for participants in the signposting group. β_2 is the coefficient for treatment allocation.

This analysis was designed to estimate the impact of taking part in STEER on the variety of offending, controlling for the variety of offending at baseline, compared to the impact of the signposting (control group that received BAU).

Deviation from the statistical analysis plan

Our original SAP proposed a repeated-measures general linear model or a generalised linear model approach, including a treatment-by-outcome interaction term. However, upon inspection of the outcome data, we determined that a negative binomial regression model was more appropriate for the SRDS variety score, given the count nature of the outcome and the overdispersion of the dataset. Instead of a repeated-measures model, we used a baseline-adjusted endpoint model, regressing the T2 SRDS variety score on the treatment group and using the T1 SRDS score as a covariate. This allowed us to appropriately handle the distributional properties of the outcome while maintaining statistical power. The analysis remains consistent with the ITT principle and YEF guidance on impact estimation.

2.9.3 Secondary analysis

Secondary outcomes were determined in line with STEER's theory of change[20] and measured using four SDQ subscales. These included:

- Improved pro-social values and behaviours, measured by the SDQ pro-social behaviour subscale

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[20] Outcomes in the theory of change around increased understanding, coping mechanisms, training/employment opportunities, career/employment aspirations and engagement with school were not included as secondary outcome measures.

- Improved emotional symptoms, measured by the SDQ emotional symptoms subscale

- Improved behaviours, measured by the SDQ conduct problems subscale

- Positive relationships/role models, measured by the SDQ peer difficulties subscale

Secondary analysis used CCA with an ITT approach, i.e. all children with valid scores for the SDQ subscales at T1 and T2 were included in the analysis in line with their original allocation. For each subscale, scores were pro-rated for children who had completed at least 60% of the scale, i.e. completed three out of five items. This approach is consistent with the YEF's SDQ guidance on handling missing data. More about the SDQ and its subscales and how they are calculated is presented in Section 2.7.

Our analysis of the impact of STEER on secondary outcomes was conducted using an analysis of covariance (ANCOVA) model, which took the following form:

$$Y_i = \beta_0 + \beta_1 Baseline_i + \beta_2 Group_i + \varepsilon_i \in N(0, \sigma^2)$$

- For $i = 1, \dots, n$ children.

Where:

- Y_i is the secondary outcomes score for participant i, measured at T2

- $Baseline_i$ is the secondary outcomes score for participant i, measured at T1.

- $Group_i$ is a dummy variable for the allocation group, i.e. coded 1 for children in the STEER group and 0 for children in the signposting group.

- β_2 is the average treatment effect.

- ε_i is the error/residual.

- σ^2 is the variance.

This analysis was designed to estimate the impact of taking part in STEER on secondary outcomes when controlling for outcomes at baseline, compared to the signposting control group.

2.9.4 Subgroup analyses

We assessed the presence of heterogeneous treatment effects in line with race equity and EDI considerations. There is limited evidence in the UK about the effectiveness of interventions which aim to reduce offending for those from racially minoritised backgrounds. As such, we explored whether STEER was equally effective for those from ethnic minority backgrounds as for those from White backgrounds. This analysis was exploratory in nature, so caution should be taken when interpreting the results.

We conducted this analysis by exploring the presence of interaction effects between ethnicity and treatment allocation in our primary analysis model. This used the following model:

$$log(\mu_i) = \beta_0 + \beta_1 Baseline_i + \beta_2 Group_i + \beta_3 Ethnicity_i + \beta_4 Ethnicity_i * Group_i$$

- For $i = 1, \dots, n$ participants

This model uses the same variables as the model set out in Section 2.9.2. In addition:

- $Ethnicity_{ij}$ is a vector of binary dummy variables which equalled 1 for children from White backgrounds and 0 for children from ethnic minority backgrounds.

- β_4 indicates the existence of heterogeneous treatment effects by ethnicity. The total treatment effect for children from ethnic minority backgrounds is β_2 and for children from White backgrounds is $\beta_2 + \beta_4$.

Deviation from the statistical analysis plan

In the SAP, we proposed conducting a subgroup analysis comparing children from Black and White ethnic backgrounds. However, due to the relatively small number of participants from individual ethnic minority groups, including those identifying as Black (i.e. 3.1% of the baseline sample identified as Black – see Table 10 later in the report), it was not feasible to conduct separate analyses with sufficient statistical power. To address this, we revised our approach and conducted subgroup analysis comparing children from White backgrounds with those from all ethnic minority backgrounds combined as one group. This grouping maximised statistical power while still enabling an exploratory examination of differential effects by ethnicity.

This deviation from the pre-specified SAP is considered analytically justifiable, given the sample constraints, but the results should be interpreted with caution. In addition, we recognise that combining children from all ethnic minority groups into a single category risks obscuring important differences in the experiences and outcomes of specific groups (Ross et al., 2020). This approach treats different ethnic groups as a homogeneous population, when in reality, there is significant diversity across cultural backgrounds, lived experiences and systemic barriers faced. Our decision was driven by the need to achieve sufficient sample sizes for analysis, but we acknowledge that this limits the nuance and interpretability of the findings. Future research with larger, more diverse samples would be needed to examine potential differential effects across specific ethnic groups.

2.9.5 Missing data analysis

Throughout the RCT, the evaluation team worked closely with the Salford Foundation team to support the collection of high-quality, complete data. However, missing data may occur in RCTs due to either item non-completion or sample attrition (i.e. children who do not complete T2 questionnaires). In line with YEF analysis guidance, we examined both the proportion of missing data in the trial and the extent and pattern of missingness in the data.

This involved analysing whether data was missing completely at random (MCAR), missing at random (MAR), or missing not at random (MNAR). MCAR and MAR indicate that complete cases are unlikely to be biased subsequent to adjustment, but they may be underpowered, whereas MNAR suggests that structural bias has been introduced to the sample.

We sought to establish the missing mechanism (i.e. which variables in the data are predictive of non-response) using logistic regression models. This modelled the presence of missing outcomes data with additional information that may be predictive of missingness. This analysis was done in line with the flow chart in Figure 3 in the YEF analysis guidance, which outlines the following approach:

- If the prevalence of missing data is less than 5%, no further action is required, as the CCA is unlikely to be biased.

- If outcomes data is MAR conditional on covariates, consider including these covariates in the primary analysis model or conduct multiple imputation for the primary outcomes analysis. The implications of any differences between the CCA and the multiple imputation analysis should be discussed in full.

- If missing data cannot be fully explained by the other variables in the dataset, the data is likely to be MNAR. In this scenario, conduct a sensitivity analysis alongside the primary impact analyses.

The above analyses were only completed for the primary outcome in line with YEF guidance, as all secondary analyses, subgroup analyses and further analyses are tentative and exploratory in nature. Further details and the results of our approach to examining missing data and mechanisms of missingness are set out in Section 3.3.5.

2.9.6   Analysis in the presence of non-compliance

Non-compliance analysis

In line with YEF guidance, our primary and secondary impact analysis followed the ITT principle, in which children were analysed according to their randomised allocation, regardless of their level of participation. ITT provides an unbiased estimate of the effect of being offered STEER but may underestimate the potential efficacy of the intervention if some participants do not adhere to their assigned treatment.

To explore this further, we conducted an exploratory complier analysis using a two-stage residual inclusion (2SRI) framework (Terza et al., 2008). This approach, sometimes referred to as a Complier Average Causal Effect analysis, provides an estimate of the causal effect of STEER among those who complied with the intervention while adjusting for potential endogeneity of compliance status.

Defining compliance

Intervention dosage was measured using monitoring data collected by the Salford Foundation, which captured the number of one-to-one face-to-face sessions received by children in both groups. In line with the programme theory, the STEER intervention was designed to deliver up to 24 sessions over the course of six months, and this provides a benchmark for assessing dosage. We therefore treat dosage primarily as a count of the number of sessions attended.

In addition, the customer relationship management system data also captured the topics discussed in each session and the additional forms of support which may be offered (including liaison with other professionals, family work and attempted contact). While some of these linked into the wraparound case work (e.g. advocacy on a child's behalf) and family support, they were not seen to be as relevant for the purposes of understanding compliance and the fidelity of the mentoring elements of STEER as face-to-face time between the mentor and the mentee.

The 2SRI model took the following approach:

1. The first stage regressed compliance status (i.e. a binary indicator for receiving ≥10 STEER sessions) on the same covariates used for the primary analysis (i.e. baseline scores and treatment allocation). This was a logistic regression model used to generate the residuals between predicted compliance and observed compliance.

2. The second stage regressed the SRDS variety score at T2 on treatment allocation, baseline scores, compliance status and the residuals from stage one to generate the 2SRI estimates.

This 2SRI framework corrects for potential selection bias in observed compliance and yields a consistent estimate of the causal effect of STEER for compliers under standard assumptions. As this was an exploratory analysis not pre-specified in the SAP, results should be interpreted with caution.

2.9.7 Additional analyses and robustness checks

Mechanism of change

In line with the theory of change underpinning the STEER intervention, the SSRS was included as a post-intervention measure of perceived relationship quality between children and their mentors or equivalent adults. The SSRS was not conceptualised as an outcome but as a potential mechanism through which STEER might generate change in offending and delinquency outcomes.

The SSRS was administered at follow-up (T2) to all participants in the intervention group and to a subsample of the signposting group who reported having a regular relationship with a trusted adult (e.g. a grandparent, sibling or teacher). Group differences were examined descriptively and using independent sample t-tests. While these analyses were exploratory, they provided insight into the extent to which STEER may have influenced the quality of the mentoring relationship and the emotional connectedness hypothesised as central to its theory of change.

Because this was a select sample (only 56% of those in the signposting group responded 'Yes' to having a trusted adult at T2 and were therefore invited to complete the full SSRS scale), it was not considered appropriate to examine this further using multivariate approaches for evidence of causality. However, exploratory correlation analyses were conducted within the STEER group to examine the relationship between the number of face-to-face sessions received and scores on the SSRS subscales. These analyses were intended to support understanding of potential dose-response mechanisms rather than to estimate intervention impact.

2.9.8 Interim analyses and stopping rules

As part of the internal pilot study, we analysed the completeness, reliability and validity of the outcomes questionnaires (including the measures of outcomes described above). We did this by conducting regular data quality audits, which explored:

- Percentages of scale item completeness

- Scale means, standard deviations and skew

- Cronbach's Alpha, testing for scale reliability, and correlation analysis, testing theoretical validity

We continued this approach for the duration of the efficacy study. Our interim analyses were completed to support the integrity and robustness of the data collection processes and did not include a comparison between those in the STEER group and the signposting group or any analyses of impact.

The trial would have stopped if the Salford Foundation, the YEF and Cordis Bright had decided that STEER was unable to recruit a sufficient number of participants. Recruitment rates were monitored against modelled monthly targets and reviewed bi-monthly as part of project group meetings. As the trial recruited the intended number of participants, this stopping rule was not applied.

In addition, the trial would have stopped if the Salford Foundation, the YEF and Cordis Bright decided that STEER was unsafe for participants. The Salford Foundation project team was responsible for safeguarding participants, and no serious adverse events occurred either overall or by trial arm. Therefore, this stopping rule was not applied.

2.9.9 Estimation of effect sizes

Effect sizes were calculated using Hedges' g, a widely used standardised measure that expresses the size of the difference between two groups in units of standard deviation. It adjusts for small sample bias and is appropriate for comparing outcomes across different measures.

All effect sizes are presented alongside model-based estimates, e.g. Exp(B), and their 95% CIs to provide a complete picture of both the size and statistical certainty of the observed effects.

For the **primary and secondary analyses,** Hedge's g was calculated using the following equation:

$$ES = \frac{(\bar{Y}_T - \bar{Y}_C)_{adjusted}}{sd_{pooled}}$$

Where:

- $(\bar{Y}_T - \bar{Y}_C)_{adjusted}$ is the adjusted difference in means between the STEER and signposting groups adjusted for baseline outcomes measures, as specified in the primary outcomes model.

- sd_{pooled} is the unconditional pooled standard deviation of the two groups.[21]

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[21] $sd_{pooled} = \sqrt{\frac{(n_1-1)sd_1^2 + (n_2-1)sd_2^2}{n_1 + n_2 - 2}}$, where n_1 and n_2 are the sample size for groups 1 and 2, respectively, and sd_1 and sd_2 are the standard deviations of group 1 and group 2, respectively.

For the **primary analysis using multiple imputation,** Hedge's g was derived from pooled regression coefficients and the pooled standard deviation, as marginal means are not pooled across imputations in SPSS. This used the following format:

1. **Cohen's d** was first computed using the following formula:

$$d = \frac{b}{Sd_{pooled}}$$

- b is the unstandardised regression coefficient from the model (i.e. the estimated treatment effect after adjusting for baseline scores).

- Sd_{pooled} is the pooled standard deviation of the outcome variable across the two groups at baseline.

2. The resulting **Cohen's d** was then adjusted using a correction factor to obtain **Hedges' g**, accounting for small sample bias:

$$ES = J \times d \text{ where } J = 1 - \frac{3}{4\,(n_1 + n_2 - 2) - 1)}$$

- J is the correction factor based on the degrees of freedom used in the pooled standard deviation.

- d is the uncorrected effect size (Cohen's d).

- n_1 is the sample size of the STEER group.

- n_2 is the sample size of the signposting group.

We reported the statistical uncertainty associated with the above effect sizes through both the CIs and the p-value. CIs were calculated using the following formula:

$$g \pm \Phi^{-1}\left(1 - \frac{\alpha}{2}\right) g_{se}$$

Where:

- Φ^{-1} is the per cent point function of the normal distribution.

- g_{se} is the standard error of the g statistic (noted as ES above). [22]

All estimations and their statistical uncertainty were reported, and the implications of both the point estimates and CIs were triangulated with the evidence collected from the IPE on the quality and context of delivery, the existence of theoretical causal mechanisms, and the experiences and perspectives of children, practitioners and wider system stakeholders who participated in semi-structured interviews.

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[22] $g_{se} = \sqrt{\dfrac{n_1 + n_2}{n_1 n_2} + \dfrac{g^2}{2(n_1 + n_2)}}$

3 Impact evaluation results

3.1 Overview

This chapter sets out the impact evaluation results from the efficacy study. It presents:

- **Participant characteristics and flow through the trial,** including an assessment of balance at randomisation, attrition rates and participant flow through the trial

- **Outcomes analysis**, including primary, secondary, subgroup and further analyses and a discussion on missing data and analysis in the presence of non-compliance

3.2 Participant characteristics and flow through the trial

Participant flow

Figure 4 sets out the CONSORT diagram for the efficacy study, which shows participant flow from referral into the trial through to final analysis of the primary outcome.

This shows the recruitment, allocation, follow-up and analysis flow for participants in the STEER study.

- A total of **1,052 children were referred** to the STEER programme, of whom 897 were deemed eligible.

- Of those, **694 agreed to participate**, with five withdrawing prior to randomisation.

- The remaining **689 children were randomised** to either the STEER intervention group (n = 337) or the signposting control group (n = 352) and **completed a T1 survey.**

- At follow-up, **524 children completed T2 surveys**. This included 261 children in the STEER group and 263 in the signposting group.

- The final sample was **514 children** who had complete data for the primary outcome (SRDS). This included 257 children in each of the STEER group and the signposting group. Children were excluded if they had missing or incomplete outcome data, which applied to 10 children. This is in line with our CCA approach (as highlighted in Section 3.3.2).

Four children allocated to the signposting group received the family support offer by mistake. These have been analysed according to their allocation in line with the ITT approach.

Figure 4. CONSORT diagram
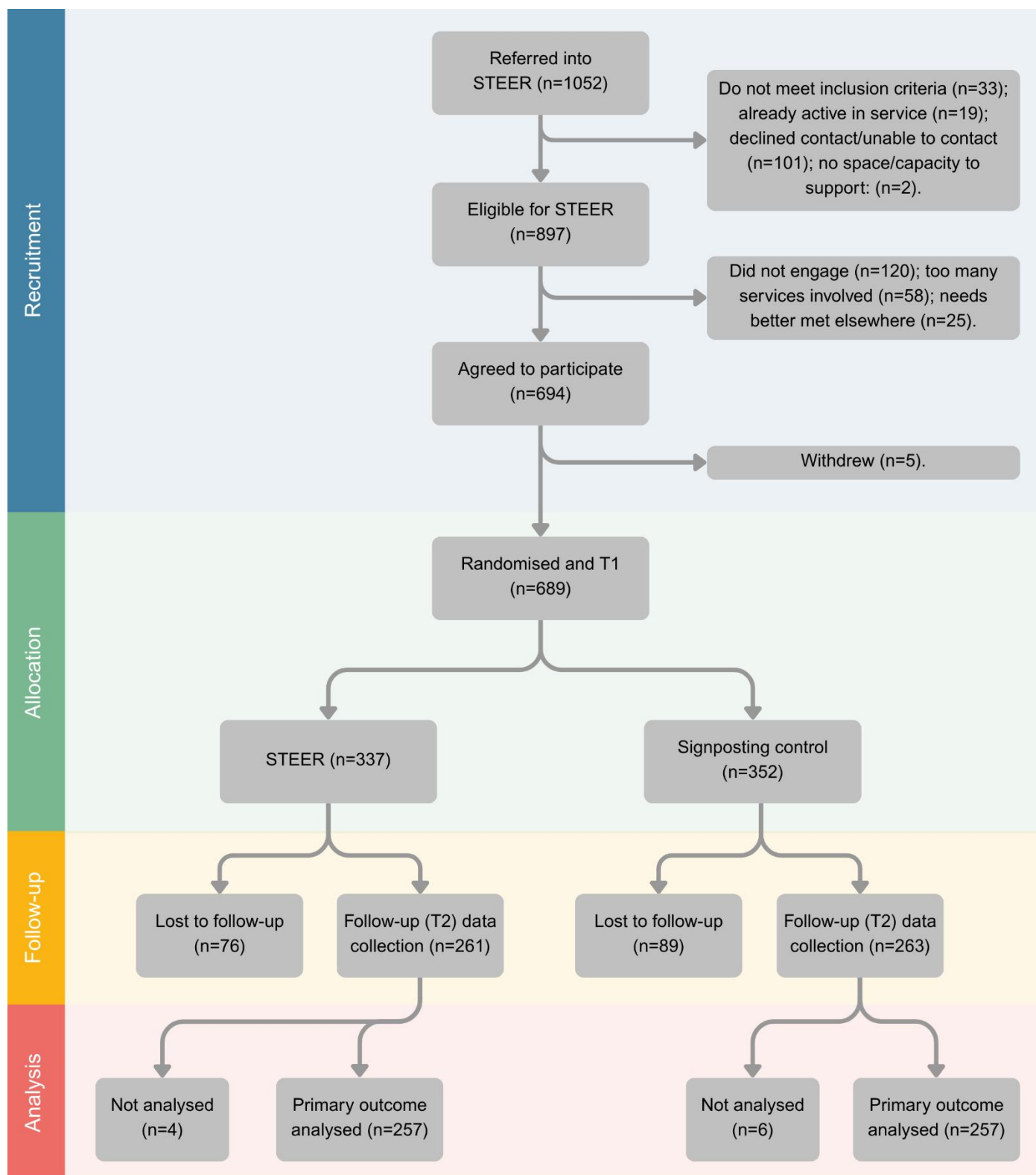
3.2.1 Participant characteristics at randomisation

Table 10 sets out the baseline characteristics of all children who were recruited to the efficacy study. It breaks down characteristics by group to enable the assessment of whether balance was successfully achieved through randomisation. This shows that the two groups were broadly similar at baseline across a range of demographic and outcome-related characteristics, suggesting that randomisation was successful.

There were no substantial differences between the STEER and signposting groups in age distribution, gender or ethnicity. The proportion of children from White ethnic backgrounds was almost identical in both groups (80.1% in STEER vs 80.2% in signposting), and the distribution across age bands was highly comparable. The gender split was also similar, with a slightly higher proportion of females in the STEER group (80.4% vs 76.1%).

Across baseline outcome measures, the two groups were well matched. The mean SRDS variety score was nearly identical (STEER: 5.11; signposting: 5.04), with a negligible effect size (Hedges' g = 0.02). Similarly, there were no meaningful differences in the SDQ subscales, with all effect sizes close to zero (ranging from −0.14 to −0.04). These small differences fall below thresholds typically used to indicate imbalance, providing further reassurance that the groups were equivalent before the intervention began.

Overall, the similarity of the groups on both demographic and baseline measures indicates that the randomisation process was successful in creating comparable groups. This strengthens the validity of the subsequent impact analysis.

Table 10. Participant characteristics at randomisation (n = 689)

	STEER group		Signposting group		
Participant-level (categorical)[23]	n/N (missing)	Count (%)	n/N (missing)	Count (%)	Effect size
Age	**337/337 (0)**		**352/352 (0)**		
10	9/337	2.67%	12/352	3.41%	
11	25/337	7.42%	37/352	10.51%	
12	47/337	13.95%	50/352	14.20%	
13	57/337	16.91%	62/352	17.61%	
14	66/337	19.58%	82/352	23.30%	
15	78/337	23.15%	59/352	16.76%	
16	41/337	12.17%	34/352	9.66%	
17	10/337	2.97%	9/352	2.56%	
18	4/337	1.19%	7/352	1.99%	

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[23] Additional baseline characteristics (e.g., accommodation type, looked after child status, physical disabilities, SEND status, current borough of residents) can be found in Table 12. Their baseline differences were negligible.

	STEER group		Signposting group		
Participant-level (categorical)[23]	**n/N (missing)**	**Count (%)**	**n/N (missing)**	**Count (%)**	**Effect size**
Gender	**337/337 (0)**		**352/352 (0)**		
Female	271/337	80.42%	268/352	76.14%	
Male	65/337	19.29%	84/352	23.86%	
Non-binary	1/337	0.30%	0/352	0.00%	
Ethnicity	**337/337 (0)**		**348/352 (4)**		
White	270/337	80.12%	279/352	80.17%	
Asian or Asian British	10/337	2.97%	10/352	2.87%	
Black, Black British, Caribbean or African	10/337	2.97%	17/352	4.89%	
Mixed or Multiple ethnic groups	37/337	10.98%	33/352	9.48%	
Other ethnic group	10/337	2.97%	9/352	2.59%	
Participant-level (continuous)	**n/N (missing)**	**Mean (SD)**	**n/N (missing)**	**Mean (SD)**	**Effect size**
Average age	337/337 (0)	13.8 (1.69)	352/352 (0)	13.6 (1.76)	
SRDS variety score	335/337 (2)	5.11 (3.46)	349/352 (3)	5.04 (3.47)	0.02
SDQ pro-social score	337/337 (0)	6.11 (2.12)	350/352 (2)	6.19 (2.14)	−0.04
SDQ emotional problems score	335/337 (2)	3.81 (2.56)	346/352 (6)	3.89 (2.55)	−0.03
SDQ conduct problems score	335/337 (2)	5.03 (1.97)	346/352 (6)	5.22 (2.03)	−0.10
SDQ peer difficulties score	335/337 (2)	2.57 (1.99)	346/352 (6)	2.84 (2.05)	−0.14

SRDS = Self-Reported Delinquency Scale, SDQ = Strengths and Difficulties Questionnaire, SD = standard deviation

Histograms of baseline scores for the SRDS variety score and four SDQ subscales were generated to assess the distribution of baseline scores, based on all participants with valid baseline (T1) data (n = 681 to 684). The distributions indicate that the measures capture a broad range of responses across the cohort, supporting their suitability for use in regression modelling. The SRDS variety score shows a moderate spread with a slight positive skew, suggesting a clustering of children reporting fewer types of offending behaviours. The SDQ pro-social subscale is negatively skewed, with most participants reporting high levels of pro-social behaviour. The SDQ emotional symptoms, conduct problems and peer problems subscales are approximately symmetric, with a mild positive skew on some scales, indicating that a smaller group of participants reported elevated levels of difficulties. Further detail is provided in Appendix C: Baseline histograms.

3.2.2 Attrition

Table 11 sets out the participant-level attrition from the trial on the primary outcome, i.e. the SRDS variety score. This shows that:

- The total attrition rate at T2 was 25.4%, with 689 children onboarded to the trial and 514 children included in the primary analysis at T2.

- Attrition rates were similar across trial arms: 23.7% for children in the STEER group, compared with 27.0% for children in the signposting group, i.e. a difference of 3.3 percentage points.

This small difference in attrition rates between groups reduces the risk of differential attrition bias and supports the internal validity of the trial's impact estimates.[24] This suggests that the observed outcomes are unlikely to have been meaningfully affected by systematic dropout related to treatment allocation.

Table 11. Participant-level attrition from the trial (primary outcome)

	STEER	Signposting	Total
Number of children randomised	337	352	689
Number of children analysed	257	257	514
Number of children lost to attrition (from randomisation to analysis)	80	95	175
Percentage of children lost to attrition (from randomisation to analysis)	23.7%	27.0%	25.4%

3.2.3 Participant characteristics throughout the trial

Table 12 presents participant characteristics at three key stages of the trial, disaggregated by trial arm: baseline (randomisation and T1), follow-up (T2) and final analysis. The purpose of this table is to assess whether any differential attrition may have introduced bias into the trial findings.

As outlined above (see Section 3.2.1), randomisation was successful in generating two well-balanced groups at baseline across key demographic characteristics and outcomes scores, including age, gender, ethnicity, and SRDS and SDQ subscales. Table 12 also shows that randomisation was successful in achieving balance across SEND status, involvement with children's services, looked-after status and language spoken at home. These were all similarly distributed between groups at baseline, suggesting no systematic imbalances in these variables.

At T2 (n = 524) and in the final analysis sample (n = 514), retention was equal across arms (n = 257 per group), and demographic characteristics remained broadly consistent between groups. There was no evidence of disproportionate loss from any specific age, gender or ethnicity. The proportions of children with SEND, looked-after status or children's services involvement also remained stable between arms and across timepoints.

These findings suggest that attrition was not systematically biased and that the analytic sample remained representative of the baseline trial population. As such, the risk of differential attrition bias is low, and the internal validity of the trial is maintained.

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[24] Please see Section 3.3.5 for more analysis concerning missing data and attrition.

Table 12. Demographic characteristics and flow through the trial

	Randomisation and T1 (n = 689)			T2 (n = 524)			Analysis (n = 514)		
	Total n (%)	STEER n (%)	Signposting n (%)	Total n (%)	STEER n (%)	Signposting n (%)	Total n (%)	STEER n (%)	Signposting n (%)
Age									
10	21 (3.0%)	9 (2.7%)	12 (3.4%)	19 (3.6%)	7 (2.7%)	12 (4.6%)	19 (3.7%)	7 (2.7%)	12 (4.7%)
11	62 (9.0%)	25 (7.4%)	37 (10.5%)	44 (8.4%)	19 (7.3%)	25 (9.5%)	43 (8.4%)	18 (7.0%)	25 (9.7%)
12	97 (14.1%)	47 (13.9%)	50 (14.2%)	81 (15.5%)	40 (15.3%)	41 (15.6%)	79 (15.4%)	39 (15.2%)	40 (15.6%)
13	119 (17.3%)	57 (16.9%)	62 (17.6%)	95 (18.1%)	47 (18.0%)	48 (18.3%)	95 (18.5%)	47 (18.3%)	48 (18.7%)
14	148 (21.5%)	66 (19.6%)	82 (23.3%)	116 (22.1%)	52 (19.9%)	64 (24.3%)	113 (22.%)	51 (19.8%)	62 (24.1%)
15	137 (19.9%)	78 (23.2%)	59 (16.8%)	100 (19.1%)	57 (21.8%)	43 (16.3%)	96 (18.7%)	56 (21.8%)	40 (15.6%)
16	75 (10.9%)	41 (12.2%)	34 (9.7%)	51 (9.7%)	31 (11.9%)	20 (7.6%)	51 (9.9%)	31 (12.1%)	20 (7.8%)
17	19 (2.8%)	10 (3.0%)	9 (2.6%)	11 (2.1%)	6 (2.3%)	5 (1.9%)	11 (2.1%)	6 (2.3%)	5 (1.9%)
18	11 (1.6%)	4 (1.2%)	7 (2.0%)	7 (1.3%)	2 (0.8%)	5 (1.9%)	7 (1.4%)	2 (0.8%)	5 (1.9%)
Average age (M ± SD)									
Age	13.7 ± 1.73	13.8 ± 1.69	13.6 ± 1.76	13.6 ± 1.69	13.8 ± 1.65	13.5 ± 1.72	13.6 ± 1.73	13.8 ± 1.69	13.5 ± 1.77
Ethnicity									
White	549 (80.2%)	270 (80.1%)	279 (80.2%)	411 (79.0%)	204 (78.2%)	207 (79.9%)	405 (79.4%)	202 (78.6%)	203 (80.2%)
Asian or Asian British	26 (3.8%)	10 (3.0%)	10 (2.9%)	20 (3.9%)	10 (3.8%)	10 (3.9%)	20 (3.9%)	10 (3.9%)	10 (4.0%)
Black, Black British, Caribbean or African	21 (3.1%)	10 (3.0%)	17 (4.9%)	23 (4.4%)	8 (3.1%)	15 (5.8%)	21 (4.1%)	7 (2.7%)	14 (5.5%)
Mixed or Multiple ethnic groups	70 (10.2%)	37 (11.0%)	33 (9.4%)	56 (10.8%)	33 (12.6%)	23 (8.9%)	55 (10.8%)	32 (12.5%)	23 (9.0%)
Other ethnic group	19 (2.8%)	10 (3.0%)	9 (2.6%)	10 (1.9%)	6 (2.3%)	4 (1.5%)	9 (1.8%)	6 (2.3%)	3 (1.2%)
Missing	4	0	4	4	0	4	4	0	4

	Randomisation and T1 (n = 689)			T2 (n = 524)			Analysis (n = 514)		
	Total n (%)	STEER n (%)	Signposting n (%)	Total n (%)	STEER n (%)	Signposting n (%)	Total n (%)	STEER n (%)	Signposting n (%)
Gender									
Male	539 (78.2%)	271 (80.4%)	268 (76.1%)	409 (78.0%)	210 (80.4%)	199 (75.7%)	400 (77.8%)	206 (80.2%)	194 (75.5%)
Female	149 (21.6%)	65 (19.3%)	84 (23.9%)	114 (21.8%)	50 (19.2%)	64 (24.3%)	113 (22.0%)	50 (19.5%)	63 (24.5%)
Non-binary	1 (0.1%)	1 (0.3%)	0 (0.0%)	1 (0.2%)	1 (0.4%)	0 (0.0%)	1 (0.2%)	1 (0.3%)	0 (0.0%)
Accommodation type									
Living with family / friends	512 (97.0%)	255 (97.7%)	257 (96.3%)	379 (96.9%)	199 (98.0%)	180 (95.7%)	370 (96.9%)	196 (98.0%)	174 (95.6%)
Children's home / foster care	4 (0.8%)	2 (0.8%)	2 (0.7%)	3 (0.8%)	1 (0.5%)	2 (1.1%)	3 (0.8%)	1 (0.5%)	2 (1.1%)
Owner occupier	2 (0.4%)	0 (0.0%)	2 (0.7%)	1 (0.3%)	0 (0.0%)	1 (0.5%)	1 (0.3%)	0 (0.0%)	1 (0.5%)
Private sector	1 (0.2%)	1 (0.4%)	0 (0.0%)	1 (0.6%)	1 (0.5%)	0 (0.0%)	1 (0.26%)	1 (0.50%)	0 (0.0%)
Don't know	9 (1.7%)	3 (1.1%)	6 (2.3%)	7 (1.79%)	2 (0.99%)	5 (2.66%)	7 (1.83%)	2 (1.00%)	5 (2.8%)
Missing	161	76	85	133	58	75	132	57	75
Children's services involved									
No	524 (76.0%)	247 (73.3%)	277 (78.7%)	411 (78.4%)	197 (75.48%)	214 (81.37%)	405 (78.79%)	196 (76.26%)	209 (81.32%)
Yes	152 (22.1%)	84 (24.9%)	68 (19.3%)	105 (20.1%)	62 (23.75%)	43 (16.35%)	101 (19.65%)	59 (22.96%)	42 (16.34%)
Don't know	13 (1.9%)	6 (1.8%)	7 (2.0%)	8 (1.5%)	2 (0.77%)	6 (2.28%)	8 (1.56%)	2 (0.78%)	6 (2.33%)
Physical disability									
No	649 (94.2%)	323 (95.8%)	326 (92.6%)	492 (93.9%)	248 (95.0%)	244 (92.8%)	482 (93.8%)	244 (94.9%)	238 (92.6%)
Yes	40 (5.8%)	14 (4.2%)	26 (7.4%)	32 (6.1%)	13 (5.0%)	19 (7.2%)	32 (6.2%)	13 (5.1%)	19 (7.4%)
SEND status									
No	434 (63.0%)	201 (59.6%)	233 (66.2%)	327 (62.4%)	154 (59.0%)	173 (65.8%)	321 (62.5%)	151 (58.8%)	170 (66.1%)
Yes	255 (37.0%)	136 (40.4%)	119 (33.8%)	197 (37.6%)	107 (41.0%)	90 (34.2%)	193 (37.5%)	106 (41.2%)	87 (33.9%)

	Randomisation and T1 (n = 689)			T2 (n = 524)			Analysis (n = 514)		
	Total n (%)	STEER n (%)	Signposting n (%)	Total n (%)	STEER n (%)	Signposting n (%)	Total n (%)	STEER n (%)	Signposting n (%)
Looked-after child									
No	677 (98.3%)	330 (97.9%)	347 (98.6%)	516 (98.5%)	256 (98.1%)	260 (98.9%)	506 (98.4%)	252 (98.1%)	254 (98.8%)
Yes	12 (1.7%)	7 (2.1%)	5 (1.4%)	8 (1.5%)	5 (1.9%)	3 (1.1%)	8 (1.6%)	5 (1.9%)	3 (1.2%)
Primary language									
English	683 (99.4%)	333 (99.1%)	350 (99.7%)	519 (99.4%)	257 (98.8%)	262 (100.0%)	509 (99.4%)	253 (98.8%)	256 (100.0%)
Arabic	1 (0.2%)	1 (0.3%)	0 (0.0%)	1 (0.2%)	1 (0.4%)	0 (0.0%)	1 (0.2%)	1 (0.4%)	0 (0.0%)
Polish	1 (0.2%)	1 (0.3%)	0 (0.0%)	1 (0.2%)	1 (0.4%)	0 (0.0%)	1 (0.2%)	1 (0.4%)	0 (0.0%)
Not asked	1 (0.2%)	1 (0.3%)	1 (0.3%)	1 (0.2%)	1 (0.4%)	0 (0.0%)	1 (0.2%)	1 (0.4%)	0 (0.0%)
Missing	2	1	1	2	1	1	2	1	1
Current borough									
Wigan	228 (33.1%)	105 (31.2%)	123 (34.9%)	157 (30.0%)	74 (28.4%)	83 (31.6%)	156 (30.4%)	74 (28.8%)	82 (31.9%)
Manchester	135 (19.6%)	69 (20.5%)	66 (18.8%)	103 (19.7%)	53 (20.3%)	50 (19.0%)	99 (19.3%)	51 (19.8%)	48 (18.7%)
Salford	117 (17.0%)	56 (16.6%)	61 (17.3%)	100 (19.1%)	49 (18.8%)	51 (19.4%)	98 (19.1%)	47 (18.3%)	51 (19.8%)
Trafford	109 (15.8%)	49 (14.5%)	60 (17.0%)	92 (17.6%)	43 (16.5%)	49 (18.6%)	91 (17.7%)	43 (16.7%)	48 (18.7%)
Tameside	75 (10.9%)	46 (13.6%)	29 (8.2%)	56 (10.7%)	35 (13.4%)	21 (8.0%)	55 (10.7%)	35 (13.6%)	20 (7.8%)
Bolton	25 (3.6%)	12 (3.6%)	13 (3.7%)	16 (3.1%)	7 (2.7%)	9 (3.4%)	15 (2.9%)	7 (2.7%)	8 (3.1%)

Note. Missing values have not been included in percentages. M = mean, SD = standard deviation, SEND = special educational needs and disabilities

3.3 Outcomes analysis

3.3.1 Overview

This section sets out the results from outcomes analysis.

Understanding the statistical terms in this section

This box explains some of the key statistical terms used in this section. These terms help us to understand whether STEER had an impact compared to the signposting control group (also referred to as BAU) and how confident we can be in the results.

- **Negative binomial regression:** A statistical model used to compare the average scores between groups (e.g. STEER vs signposting), controlling for their starting scores. It is used when the outcome is a count (e.g. the number of different types of offences a child reports) and when the data is more variable than expected.

- **ANCOVA:** A statistical model used to compare the average scores between groups (e.g. STEER vs signposting) while adjusting for their starting scores. It is used when the outcome is continuous (e.g. when comparing subscale scores from the SDQ).

- **Unadjusted mean:** The simple average outcomes score for a group at follow-up, without accounting for any baseline differences.

- **Adjusted mean:** The average score for a group, calculated after accounting for differences at the start of the trial between groups (e.g. baseline scores). This gives a fairer comparison between groups.

- **Hedges' g:** A standardised effect size which measures the size of the difference between groups. It is an interchangeable version of Cohen's d that adjusts for small sample sizes and ranges from 0 to 1. For measures where an <u>increase</u> in scores or a positive effect size (g > 0) is interpreted positively, in line with <u>YEF's Technical Guide (2025)</u>, the thresholds used in this report are as follows:

    g < −0.02 = Harmful

    −0.02 ≤ g < 0.02 = No effects

    0.02 ≤ g < 0.10 = Small effects

    0.10 ≤ g < 0.25 = Moderate effects

    g ≥ 0.25 = High effects

    Where the start point of each given range is part of the relevant effect size, while the end point marks the start of the next interval.

    For measures where a <u>decrease</u> in scores or a negative effect size (g < 0) is interpreted positively (i.e. fewer difficulties or a reduction in offending variety), the thresholds should be reversed before interpreting the Hedges' g. For example, a Hedges' g of −0.20 on offending would be interpreted as a moderate effect, while a Hedges' g of 0.34 on offending would be interpreted as harmful.

- **Confidence interval (CI):** A range that we are fairly sure contains the true effect. For example, a 95% CI of 0.89 to 1.27 means we are 95% confident that the true result lies between those two numbers. If the

range includes 1 (for ratios) or 0 (for effect sizes), the effect is not statistically significant, and we cannot determine whether the true effect is different from 0.

- **The p-value:** This shows the likelihood that the observed result happened by chance. A p-value of less than 0.05 is typically considered statistically significant, meaning the result is unlikely to be due to random variation.

- **Exp (B) (Exponential of the regression coefficient):** This is used in models such as logistic or negative binomial regressions. It tells us how much more (or less) likely an outcome is in one group compared to another.

   Exp(B) = 1 means no difference in the likelihood of the outcome between groups.

   Exp(B) > 1 means the outcome is more likely in one group than another.

   Exp(B) < 1 means the outcome is less likely in one group than another.

- **Pearson's r (correlation coefficient)**: A measure of the strength and direction of a relationship between two variables. It ranges from −1 to +1:

   A value of +1 means a perfect positive relationship (as one variable increases, so does the other).

   A value of −1 means a perfect negative relationship (as one variable increases, the other decreases).

   A value of 0 means no relationship between the variables.

Additional statistical terms are included and explained throughout this section where relevant.

3.3.2 Primary analysis

Primary analysis was conducted on the SRDS variety score, using a negative binomial regression to account for the count nature of the variable and overdispersion, as discussed in Section 2.9.2. This analysis was conducted using an ITT approach on complete cases, such that all children with a valid SRDS variety score at baseline (T1) and follow-up (T2) were included in the analysis, in line with their original allocation to either the STEER group or the signposting group. A total of 514 children were included in this analysis.

Table 13 summarises the findings from the primary analysis. This sets out (1) the unadjusted mean for the SRDS variety score across groups at follow-up (T2) and (2) the estimated Hedges' g effect size, associated CI and p-value for the treatment estimate. For this subscale, a decrease in scores is interpreted positively, as it means that the variety of offending has decreased.

Table 13 shows that allocation to STEER was associated with a statistically non-significant, negligible increase in the variety of self-reported offending (Hedges' g = 0.08). This effect was not statistically significant (p = 0.385), and the 95% CI included zero, indicating uncertainty around the direction and magnitude of the true effect. Consequently, the finding does not provide clear evidence that participation in STEER increased or reduced offending behaviour compared with the control group. Rather, it suggests that any true effect, positive or negative, was small and that the trial, which was powered to detect moderate effects (MDES ≥ 0.19), was not able to detect such a small difference with confidence.

Table 13. Primary complete case analysis summary (n = 514)

| Outcome | Unadjusted means at T2 | | | | Effect size | | |
| | Intervention group | | Signposting group | | | | |
	n (missing)	Mean (95% CI)	n (missing)	Mean (95% CI)	Total n (STEER; signposting)	Hedges' g (95% CI)	p-value
SRDS variety score	257 (80)	3.53 (3.16, 3.90)	257 (95)	3.26 (2.92, 3.60)	514 (257; 257)	0.08 (−0.10, 0.26)	0.385

CI = confidence interval; SRDS = Self-Reported Delinquency Scale

Difference in unadjusted means

Table 14 presents the descriptive statistics for the SRDS variety score for children in the STEER group and the signposting group at both baseline (T1) and follow-up (T2). Descriptive statistics show that both groups reported fewer types of offending and delinquency behaviours at follow-up compared to baseline.[25] At baseline, mean variety scores were similar between groups (STEER = 5.06; signposting = 5.02), and by follow-up, these had reduced to 3.53 in the STEER group and 3.26 in the signposting group. The standard deviations also reduced slightly, indicating a modest overall decrease in offending variety within both groups.

Table 14. Difference in unadjusted means of the Self-Reported Delinquency Scale (SRDS) variety score at T1 and T2, broken down by treatment group for the complete case analysis sample (n = 514)

Time period	Group	N	Mean	SD	SE	t statistic	p value
SRDS T1	STEER	257	5.06	3.35	0.21	0.12	0.906
	Signposting	257	5.02	3.38	0.21		
SRDS T2	STEER	257	3.53	2.99	0.19	1.04	0.299
	Signposting	257	3.26	2.78	0.17		

SD = standard deviation; SE = standard error.

Regression model

Table 15 presents the results of a negative binomial regression model exploring the effect of STEER on the variety of self-reported offending behaviours at follow-up (T2), controlling for baseline (T1) SRDS scores. The key findings are:

- **Group allocation (STEER vs signposting)** was not statistically significantly related to offending variety at follow-up (b = 0.09, *p* = 0.385). The 95% CI for Exp(B) (0.89 to 1.33) includes 1, indicating uncertainty about the true direction of the effect. The estimated Exp(B) of 1.09 implies that children

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[25] This may be for a range of reasons, including (1) testing effects, whereby young people become less likely to answer yes to an offence when they realise it prompts additional follow up questions, or (2) recall periods, because the T1 questionnaire asked about the previous 12 months and the T2 questionnaire asked about the previous six months. As a result, unadjusted means are not directly comparable across waves. In principle, this difference should be partialled out across groups through the trial design, but it nevertheless introduces an added layer of uncertainty when interpreting individual-level change over time. However, further research would be needed to understand which, if any, factors may have influenced self-reported offending via the SRDS.

in the STEER group had, on average, a 9% higher offending variety score at follow-up than those in the control group – however, this difference was small and not statistically significant.

- **Baseline offending (SRDS T1)** was strongly and significantly associated with offending variety at follow-up (b = 0.13, p < 0.001). The Exp(B) value of 1.13 suggests that for each additional type of offence reported at baseline, the expected number of offence types at follow-up increased by approximately 13%, holding group allocation constant. This indicates that higher baseline offending is associated with greater offending variety at follow-up.

The estimated regression coefficient corresponded to a standardised mean difference of 0.09. Applying the small-sample correction yielded a Hedges' g of 0.08 (see Table 13). However, this effect was not statistically significant, and the CI included zero, suggesting uncertainty around its true direction, indicating that any difference between groups, whether positive or negative, was small and unlikely to be detected reliably within the trial's MDES.

Table 15. Results from the negative binomial regression of the Self-Reported Delinquency Scale (SRDS) variety score at T2 on treatment allocation and baseline scores (n = 514)

Variable	b	Std. Error	Lower	Upper	Wald Chi-Square	df	p value	Exp(B)	Lower	Upper
Intercept	0.46	0.11	0.24	0.68	16.66	1	<0.001	1.58	1.27	1.97
SRDS T1	0.13	0.02	0.09	0.16	61.76	1	<0.001	1.13	1.10	1.17
STEER	0.09	0.10	−0.11	0.29	0.76	1	0.385	1.09	0.89	1.33

Although participation in STEER was associated with a small increase in the variety of self-reported offending compared with the signposting group, this difference was not statistically significant (Hedges' g = 0.08), and both groups reported lower average offending variety at follow-up than at baseline. However, caution is needed when interpreting this apparent reduction over time, as it is possible that the observed decrease reflects testing effects or differences in recall periods between survey waves, rather than genuine behavioural change. This indicates that the study was unable to detect a small effect of this size with confidence and that any true difference between groups, whether positive or negative, was likely small and uncertain. As such, the direction and magnitude of the change in offending variety should be interpreted with care.

3.3.3 Secondary outcomes analysis

Secondary analysis was conducted on four SDQ subscales to assess:

- **Improved pro-social values and behaviours** measured by the SDQ pro-social behaviours subscale. For this subscale, an <u>increase</u> in scores and a Hedges' g > 0 is interpreted positively, indicating that pro-social behaviours have improved.

- **Improved emotional symptoms** measured by the SDQ emotional symptoms subscale. For this subscale, a <u>decrease</u> in scores and a Hedges' g < 0 is interpreted positively, indicating that emotional difficulties have decreased and emotional symptoms have improved.

- **Improved behaviour** measured by the SDQ conduct problems subscale. For this subscale, a <u>decrease</u> in scores and a Hedges' g < 0 is interpreted positively, indicating that conduct difficulties have decreased and behaviour has improved.

- **Improved positive relationships/role models** measured by the SDQ peer difficulties subscale. For this subscale, a <u>decrease</u> in scores and a Hedges' g < 0 is interpreted positively, indicating that peer difficulties have decreased and positive relationships have improved.

As described in Section 2.9.3, secondary analysis was conducted on complete cases using an ITT approach. This was conducted using an ANCOVA model to assess the impact of allocation to STEER on secondary outcomes at follow-up (T2), controlling for baseline scores. This analysis was conducted for between 516 and 522 children, varying by subscale.

Table 16 presents the results of the secondary analysis examining the four secondary outcomes measured by the SDQ. At six months post-randomisation, the findings indicate that participation in STEER was not statistically significant, with small to moderate positive effects across all outcomes except conduct problems, which had no effect. As these differences did not reach statistical significance and the CIs included zero, the between-group differences should be interpreted with caution. Specifically:

- **Pro-social behaviour.** The estimated effect was Hedges' g = 0.02 (p = 0.763). Because higher scores indicate greater pro-social behaviour, this small effect represents a non-significant difference in the favourable direction for STEER. However, as the CI included zero, we cannot reliably conclude that STEER improved pro-social behaviour.

- **Emotional symptoms.** The estimated effect was Hedges' g = −0.14 (p = 0.142). This represents a statistically non-significant reduction in emotional difficulties among STEER participants – a favourable direction for STEER, which is consistent with the theory of change. However, the CI included zero, so the true size and direction of the effect remain uncertain.

- **Conduct problems.** The estimated effect was Hedges' g = 0.02 (p = 0.812), which, given that positive scores indicate greater conduct difficulties, suggests no measurable difference between the STEER and control groups on conduct problems.

- **Positive relationships/role models (peer difficulties).** The estimated effect was Hedges' g = −0.07 (p = 0.325). As lower scores indicate fewer peer difficulties, the positive direction represents a non-significant and favourable direction in peer relationships for STEER participants. The CI included zero, so the true size and direction of the effect remain uncertain.

These results indicate that allocation to STEER produced statistically non-significant favourable effects on pro-social behaviour, emoti   onal symptoms and positive relationships/role models, though the true effects remain uncertain given that the CIs include zero.

Table 16. Secondary analysis summary (n = 516 to 522)

Outcome	Unadjusted means				Effect size		
	STEER group		Signposting group				
	n (missing)	Mean (95% CI)	n (missing)	Mean (95% CI)	Total n (STEER; signposting)	Hedges' g (95% CI)	p-value
Pro-social behaviour	261 (76)	6.30 (6.05, 6.25)	261 (91)	6.30 (6.05, 6.25)	522 (261; 261)	0.02 (−0.14, 0.18)	0.763
Emotional symptoms	259 (78)	3.52 (3.23, 3.82)	257 (95)	3.84 (3.52, 4.16)	516 (259; 257)	−0.14 (−0.32, 0.04)	0.142
Conduct problems	259 (78)	4.44 (4.20, 4.68)	258 (94)	4.47 (4.21, 4.73)	517 (259; 258)	0.02 (−0.16, 0.20)	0.812
Positive relationships / role models	261 (76)	2.66 (2.43, 2.89)	261 (91)	2.93 (2.68, 3.18)	522 (261; 261)	−0.07 (−0.25, 0.11)	0.325
CI = confidence interval							

3.3.4 Subgroup analyses

An exploratory subgroup analysis was conducted on the SRDS variety score to explore whether the impact of allocation to STEER varied for children from White backgrounds compared to children from ethnic minority backgrounds. Although the overall effects for the entire cohort were not statistically significant, such analysis remains valuable, as it can indicate whether an intervention tends to work better or worse for certain groups of children.

As described in Section 2.9.4, subgroup analysis was conducted using a negative binomial regression model, regressing the expected SRDS variety score at T2 on treatment allocation, baseline scores, ethnicity and an interaction between ethnicity and treatment allocation. This analysis was conducted for 510 children with complete data for the SRDS variety score at baseline (T1) and follow-up (T2) and data recorded on ethnicity.

Table 17 sets out the results of this analysis. The findings indicate that the impact of STEER did not differ meaningfully by ethnicity, with no statistically significant interaction effects observed. Specifically:

- **Children from White backgrounds:** Allocation to STEER was associated with a statistically non-significant increase in the SRDS variety score (Hedges' g = 0.08, p = 0.426).

- **Children from ethnic minority backgrounds:** Allocation to STEER was associated with a statistically non-significant increase in the SRDS variety score (Hedges' g = 0.10, p = 0.627).

Both subgroups, therefore, showed statistically non-significant effects of similar magnitude, indicating that those participating in STEER may have reported a slight increase in their SRDS variety scores. CIs included zero, suggesting uncertainty around the true direction of the effects. These results provide no clear evidence that STEER's impact varied by ethnic background. However, the analysis is exploratory and likely underpowered due to small subgroup sizes. Findings should, therefore, be treated with caution. Future research with larger, more diverse samples, sufficiently powered for equity analysis, would be needed to test whether any differences in impact exist between ethnic groups without collapsing categories.

Table 17. Subgroup analysis on the primary outcome by ethnicity (n = 510)[26]

| Outcome/ group | Unadjusted means | | | | Effect size | | |
| | STEER group | | Signposting group | | | | |
	n (missing)	Mean (95% CI)	n (missing)	Mean (95% CI)	Total n (STEER; signposting)	Hedges' g (95% CI)	p-value
White background	202 (68)	3.65 (3.22, 4.08)	203 (76)	3.41 (3.01, 3.81)	405 (202; 203)	0.08 (−0.12, 0.28)	0.426
Ethnic minority background	55 (12)	3.07 (2.44, 3.70)	50 (19)	2.78 (2.14, 3.42)	105 (55; 50)	0.10 (−0.29, 0.59)	0.627

CI = confidence interval

3.3.5 Missing data analysis

This section assesses the role of missing data in the primary and secondary analysis. As described in Section 2.9.5, our approach involves estimating both (1) the prevalence of missing data and (2) the mechanisms of missingness, i.e. determining which factors may be predictive of missingness and running further analyses accordingly. The next two sections set out the findings related to both analyses.

Prevalence of missing data

Missing data can be introduced into an RCT via two mechanisms:

1. Survey non-completion, i.e. where a child may have completed a survey at baseline (T1) but did not complete a survey at follow-up (T2). This is often referred to as missing units.
2. Item non-completion, i.e. where a child completed a survey but did not complete enough items within that survey to enable the calculation of an outcomes score. This is often referred to as missing items.

Table 18 sets out the prevalence of missing data across the trial and sets out the extent of survey non-completion and item non-completion. As described in Section 3.2, 689 children were recruited to the trial overall, with 337 allocated to the STEER group and 352 allocated to the signposting group. Of these, all 689 children completed a baseline questionnaire, and 524 children completed a T2 questionnaire. This means that there were approximately 165 cases of missing data due to missing units.

For the primary outcome analysis, Table 18 also shows an additional 10 cases of missing data due to missing items. This is where a child completed both a baseline and follow-up survey, but a valid SRDS variety score could not be constructed at either T1 or T2, as the child did not complete enough survey items. Four children in the STEER group and six children in the signposting group were excluded from the final analysis due to item non-response. Appendix D: Prevalence of missing items sets out the distribution of missing items from the SRDS at T1 and T2.

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[26] Please note that four young people who feature in the primary CCA had missing data for ethnicity, and therefore were not included in the analysis in this section.

Taken together, this means that the final prevalence of missing data across both arms was 175 children, with a total attrition rate of 24.5% between randomisation and follow-up data collection. As a rule of thumb, missing data below 5% is typically considered negligible. Therefore, the level of attrition in this trial is considered moderate to substantial. This may introduce bias to the results, particularly if the children who did not complete follow-up questionnaires differ systematically from those who did – for instance, if they were more or less likely to benefit from STEER. The mechanisms underlying this missingness, therefore, warrant further exploration, and the results of this are set out in the following section.

Table 18. Number of missing cases for the primary analysis (n = 689)

Outcome	STEER group (n = 337)			Signposting group (n = 352)		
	Unit missing n (%)	Item missing n (%)	Total missing n (%)	Unit missing n (%)	Item missing n (%)	Total missing n (%)
SRDS variety score	76 (22.8%)	4 (0.9%)	80 (23.7%)	89 (24.7%)	6 (2.3%)	95 (27.0%)

SRDS = Self-Reported Delinquency Scale

Establishing mechanisms of missingness

Before deciding how to deal with missing data, it is important to understand why data might be missing. This matters because if certain types of children are more or less likely to complete follow-up questionnaires, this could bias the study results and affect how confidently we can draw conclusions about the impact of STEER.

Generally, missing data is classified into three broad categories, based on the likely reason that data is missing:

- **MCAR**. This missingness is unrelated to anything relevant to the study. For example, a child might miss their survey meeting because of train strikes – this has nothing to do with who they are or what their outcomes are. This is the least problematic type of missing data.

- **MAR**. This missingness is related to other known information about the child, such as age or baseline behaviour, but not to the missing outcomes data itself. If MAR is a reasonable assumption, we can use statistical techniques (such as multiple imputation) to account for the missing data without introducing bias into the study results.

- **MNAR**. This missingness depends on the unobserved outcome or on factors for which we do not have data, for example, if children who continued to offend were less likely to complete a T2 questionnaire than children who did not continue to offend. This is the most difficult type of missingness to address, as it introduces potential bias that cannot be easily corrected using standard methods.

Our approach to handling missing data followed YEF analysis guidance and was grounded in an assessment of the missing data mechanism.

Given that the proportion of missing data was over 5%, it was reasonable to assume that the data were not MCAR. To verify this, we conducted Little's MCAR test (Little and Schenker, 1995), which indicated that the data were not MCAR.

While it is not possible to directly test whether data are MAR, it is possible to investigate the plausibility of this assumption. To do this, we conducted a logistic regression to assess which, if any, demographic characteristics were predictive of missingness. This modelled a binary indicator for T2 completion (coded 1 for missing T2 data and 0 for complete T2 data) on the covariates of treatment allocation, age, ethnicity, gender and SRDS variety score at baseline (T1).

Table 19 sets out the results from this regression. This suggests that:

- **Age was a significant predictor of missingness** (Exp(B) = 0.86, p = 0.005). This means that older children were significantly less likely to complete a T2 questionnaire and that the likelihood of completing a T2 questionnaire decreased by 14% with each additional year.

- There was **no evidence that ethnicity, gender, treatment allocation or baseline SRDS variety scores** predicted missingness at T2. None of these four variables was statistically significant, and the CIs for the Exp(B) values include one in all cases, which means we cannot be certain of the effect direction.

Together, these findings suggest that it is plausible that the data is MAR, as missingness appears to be explained by observed characteristics, such as age. On this basis, we proceeded with multiple imputation to address missing data, which is outlined in the sections below.

Table 19. Logistic regression on the probability of missing data at T2 (n = 689)

Variable	B	S.E.	Wald	Df	p-value	Exp(B)	Lower	Upper
Ethnicity	0.34	0.24	1.98	1	0.16	1.40	0.88	2.25
STEER/Control	−0.21	0.18	1.27	1	0.26	0.81	0.57	1.16
Age	−0.15	0.05	8.00	1	0.005	0.86	0.78	0.96
Gender	0.05	0.22	0.04	1	0.837	1.05	0.68	1.62
SRDS T1	−0.01	0.03	0.04	1	0.849	1.00	0.95	1.05

SRDS = Self-Reported Delinquency Scale

Multiple imputation model

We deployed a multiple imputation model to impute missing data, based on findings that an assumption of MAR is plausible. Multiple imputation is a method which creates several different versions of the original dataset, where the missing outcome values are filled in (i.e. imputed) using available information from the rest of the dataset. For example, if a child's follow-up outcome score is missing, a multiple imputation model uses other available information about this child, such as their age, gender, baseline scores or ethnicity, to estimate what their score might have been based on other similar children. This process is repeated multiple times to reflect the uncertainty around those estimates, and for each missing value, several plausible values are generated based on the relationships between variables in the observed data. Each version of the dataset is analysed separately, and the results are then combined. This provides a more accurate and statistically robust estimate than either filling in missing data once or ignoring it altogether.

Although MAR is not a testable assumption, multiple imputation models are fairly robust to some violations of the MAR assumption, especially when additional variables that are not in the primary analysis but are related to missingness are used in addition to the primary analysis variables (Li and Stuart, 2019). If the MAR assumption is met, these methods will provide an unbiased estimate of the intervention effect as if no

subjects had missing entries (i.e. across hypothetical repeated replications of the study, these methods would, on average, give accurate parameter estimates, such as regression coefficients [Dong and Maynard, 2013]).

While only age was found to be significantly predictive of missingness, age, gender and ethnicity were also included in the imputation model because they are likely to improve the prediction of outcome values. Including these auxiliary variables is consistent with best practice guidance on multiple imputation (White et al., 2011), as it can enhance the plausibility of the MAR assumption and improve the efficiency of parameter estimates.

The multiple imputation model was run using 15 demographic and outcome variables, including ethnicity, gender and age, as well as the 10 scales of the SDQ (five subscales at both T1 and T2) and the SRDS variety scores (at both T1 and T2). Including the SSRS was considered, but this scale was administered only once to those in the STEER and signposting group at follow-up (T2). In addition, only those in the signposting group who reported a trusted adult completed it. Other potential auxiliary variables collected as part of the case monitoring system were not considered sufficiently robust to include in the multiple imputation. Multiple imputation was conducted using five datasets. This is because five imputations are considered a practical balance between computational efficiency and statistical accuracy. That is, the improvement in precision gained by increasing the number of imputations is often negligible (von Hipple, 2018).

Table 20 compares key descriptive statistics (mean, median and standard deviation) for the original data and the multiply imputed dataset across both time points (T1 and T2) and trial groups. The results show that the means and standard deviations for the imputed datasets are **very similar** to those from the original data. For example:

- In the STEER group at T2, the mean SRDS score increased slightly from **3.58** to **3.66** after imputation.

- In the signposting (control) group at T2, the mean increased from **3.28** to **3.47**.

- Standard deviations changed only marginally (e.g. from 3.00 to 2.95 for STEER T2), indicating that variability in the data was preserved.

The small, consistent shifts in the group means following imputation reflect the inclusion of plausible estimated values for children with missing T2 responses. These modest differences are expected and suggest that the imputation process behaved appropriately, i.e. introducing no distortion while slightly adjusting the outcome values in a way that reflects the broader characteristics of the sample. This comparison shows that multiple imputation produced plausible and stable estimates that preserved the overall shape and distribution of the original data, strengthening confidence in the validity of the outcome analysis that follows.

Table 20. Self-Reported Delinquency Scale variety score – descriptive statistics with and without multiple imputation

| | Original | | | | | | Multiple imputation | | | |
Group	N	Mean	Median	SD	Skewness	Kurtosis	N	Mean	Median	SD
STEER T1	335	5.13	4.24	3.45	0.84	0.51	337	5.11	4.00	3.45
STEER T2	258	3.58	3.00	3.00	1.30	2.17	337	3.66	3.00	2.95

	Original						Multiple imputation			
Group	N	Mean	Median	SD	Skewness	Kurtosis	N	Mean	Median	SD
Control T1	349	5.07	4.24	3.47	0.90	0.59	352	5.06	4.00	3.47
Control T2	259	3.28	3.00	2.79	1.34	2.03	352	3.47	3.00	2.76

SD = standard deviation

Multiple imputation model on the primary outcome analysis

Table 21 presents the primary analysis on the imputed datasets. As with the primary analysis conducted using CCA, set out in Section 3.3.2, this analysis used a negative binomial generalised linear regression model to assess the impact of allocation to STEER on the variety of offending at T2, controlling for baseline scores.

Table 21 shows that there was no statistically significant association between allocation to STEER and a reduction in the variety of offending using the multiple imputation model. The estimated Hedges' g = −0.01 (p = 0.583) falls within the YEF's no effect range (−0.02 ≤ g < 0.02), indicating no measurable difference between groups. This model, therefore, supports the interpretation that STEER had no measurable impact on offending variety.

Table 21. Primary outcome analysis results using multiple imputation (n = 689), compared with complete case analysis (n = 514)

Outcome	Unadjusted means				Effect size		
	STEER group		Signposting group				
	n (missing)	Mean (95% CI)	n (missing)	Mean (95% CI)	Total n (STEER; Signposting)	Hedges' g (95% CI)	p-value
SRDS variety score (complete case)	257 (80)	3.53 (3.16, 3.90)	257 (95)	3.26 (2.92, 3.60)	514 (257;257)	0.08 (−0.10, 0.26)	0.385
SRDS variety score (multiple imputation)	337 (0)	3.66 (3.35; 3.98)	352 (0)	3.47 (3.18, 3.76)	689 (337; 352)	−0.01 (−0.19, 0.17)	0.583

CI = confidence interval; SRDS = Self-Reported Delinquency Scale

Triangulating both the complete case and multiple imputation analyses suggests that the evidence in this trial of the impact of STEER on children's variety of self-reported offending is inconclusive. Both approaches yielded near-identical findings, showing no statistically significant difference between the STEER and signposting groups on the primary outcome of the variety of self-reported offending. The small effect observed in the complete case analysis (Hedges' g = 0.08) and the null effect in the imputed analysis (Hedges' g = −0.01) both fall below the trial's MDES and within the small or no effect YEF classification ranges. In both analyses, the CIs included zero, which suggests that the direction of the effect is uncertain. This strengthens the conclusion that the small unfavourable difference observed in the complete case sample reflects random sampling variation rather than a systematic programme effect. The overall evidence should therefore be characterised as statistically non-significant and substantively null.

The analysis suggests that the pattern of missing data did not bias or meaningfully distort the results and that the assumption of data being MAR was reasonable. In practical terms, the findings provide no evidence of a measurable difference between groups on the primary outcome within the six-month follow-up period

and support the conclusion that the absence of statistically significant effects is not an artefact of missing data or the analytical approach. This result suggests that missing data did not meaningfully bias the findings.

3.3.6   Analysis in the presence of non-compliance

The analysis presented so far has followed an ITT approach. This means all participants are analysed according to the group to which they were originally randomised, regardless of which group they ended up receiving or their level of engagement with STEER. This approach preserves the benefits of randomisation, provides a conservative causal estimate and reflects real-world implementation conditions, including challenges with take-up and adherence.

However, when ITT analyses yield statistically non-significant, negligible, small or moderate effects, it is important to explore whether this may be driven by limited engagement with the intervention. In these cases, analysis in the presence of non-compliance can provide additional insight. These methods aim to estimate the average effect of the intervention among those who complied with it, that is, children who actually received STEER as it was intended to be delivered. This addresses the question: *"What was the effect of STEER for children who received it as intended?"* However, because this analysis compares subgroups that are no longer generated by randomisation (because children who engaged with STEER are likely to be different from children who did not), it does not retain all the causal advantages of an ITT analysis. As such, these estimates should be interpreted with caution and understood as exploratory rather than definitive.

As described in Section 2.9.6, to further explore the impact of receiving a higher dose of STEER mentoring, a 2SRI analysis was conducted. This analysis is complementary to the interpretation of the ITT findings and informs understanding of the role that adherence and engagement may have played in shaping overall outcomes. This method adjusts for potential confounding in observational estimates of treatment dose by using random assignment as an instrument for compliance. In other words, it helps us understand whether receiving more sessions made a difference to outcomes, while taking into account that some children may have been more likely to attend sessions in the first place.

The 2SRI analysis was completed in the following two stages:

Stage 1: predicting compliance

A logistic regression model was used to predict which participants received a high dose of mentoring (defined as 10 or more face-to-face sessions) based on their random allocation (STEER vs signposting) and their baseline SRDS variety score (T1). The key purpose of this model was to obtain residuals that capture the unexplained variance in session attendance for use in the second stage of the analysis.

As discussed in Section 2.9.6, the compliance threshold of 10 or more sessions was decided post hoc. While the original SAP proposed 18 sessions as the benchmark for compliance, descriptive analysis showed that this threshold would exclude a high proportion of participants. A cut-off of 10 sessions was therefore selected, as it was approximately the average number of sessions received among the STEER group. However, this change constitutes a protocol deviation, and this threshold is still well below the intended dosage of the STEER programme, which is 24 weekly face-to-face sessions. As such, this redefinition of compliance should be interpreted with caution and may underestimate the potential impact of the full intervention. Importantly, it reflects a substantially reduced version of STEER's intended offer, meaning this analysis explores the effect of partial engagement rather than full programme participation.

The model was statistically significant ($\chi^2(2) = 457.518$, $p < 0.001$), and explained a substantial proportion of the variance in attendance (Nagelkerke $R^2 = 0.795$). This model was used to generate residuals, which were retained for use in Stage 2.

Stage 2: estimating treatment effects with compliance residuals

A negative binomial regression was then conducted in which SRDS variety scores at T2 were regressed on baseline SRDS scores (T1), the dichotomised session attendance variable (0–9 vs 10 or more sessions) and the residuals from Stage 1. This model aimed to assess whether receiving a higher dose of mentoring was associated with reduced variety of offending, after accounting for baseline scores and the predicted likelihood of compliance. Given the low delivered dose and the change to the planned compliance threshold, complier effect estimates have limited causal interpretability and should be treated as exploratory.

The results are presented in Table 22. These results show that:

- Neither the compliance indicator nor the residuals predicting compliance were significantly associated with SRDS variety scores at follow-up (p-values of 0.899 and 0.930, respectively).

- Baseline SRDS variety scores remained a significant predictor of follow-up outcomes, indicating stability in self-reported offending over time.

Table 22. Second stage two-stage residual inclusion regression (n = 514)

	B	SE	Lower	Upper	Wald	df	p-value	Exp(B)	Lower CI	Upper CI
Intercept	0.57	0.12	0.33	0.81	20.97	1	<0.001	1.77	1.39	2.25
Compliance status	−0.11	0.12	−0.35	0.14	0.74	1	0.390	0.90	0.71	1.15
Residuals	−0.07	0.23	−0.52	0.37	0.10	1	0.750	0.93	0.60	1.45
SRDS T1	0.13	0.02	0.09	0.16	61.09	1	<.001	1.13	1.10	1.17

SRDS = Self-Reported Delinquency Scale

In addition, estimated marginal means suggest a modest, non-significant difference in SRDS T2 scores between children who received fewer than 10 sessions (M = 2.99) and those who received 10 or more sessions (M = 3.32). However, this difference was not significant, and the CIs overlapped substantially.

These exploratory analyses suggest that receiving additional sessions up to the level achieved in practice was not associated with statistically significant reductions in the variety of offending. The direction of the effect was small and uncertain. However, because this analysis captures only partial engagement (10+ sessions out of an intended 24), it remains unclear whether full adherence to the intended model would have been associated with stronger effects. Combined with the ITT findings, this analysis suggests that variation in outcomes was not explained by differing levels of engagement among participants within the limits of delivery achieved in this trial. Future implementation should prioritise strategies to increase session completion and support children to ensure more consistent engagement. Further insights into the fidelity and dosage of STEER can be found in Section 5.1.

3.3.7   Additional analyses and robustness checks

The STEER programme is designed to build trusted relationships between children and mentors, which are theorised to underpin behaviour change. This section explores whether children in the STEER group reported stronger relationship quality than those in the signposting group and whether greater engagement with mentoring was associated with stronger relationship quality. To explore this, correlations were examined between the number of one-to-one sessions attended and SSRS subscale scores among children in the STEER group.

To assess this, the SSRS was administered at follow-up (T2) to all children in the STEER group and to children in the signposting group who reported having a trusted adult.

The SSRS includes four subscales:

- **Feels valued** (e.g. "This person cares about how I am doing in school").

- **Trust** (e.g. "I feel safe when I am with this person").

- **Mentoring** (e.g. "This person introduces me to new ideas or experiences").

- **Negativity** (e.g. "I don't like things this person says or does").

Higher scores on the first three subscales indicate stronger, more supportive relationships, while higher scores on the negativity subscale indicate a poorer relationship.

The SSRS was collected only at T2. In the control group, it was administered only to those who said yes to the question: *"Do you have a relationship with a significant adult, other than a parent, who you see on a regular basis?"* Of the 241 children in the control group who answered this question, only 135 (56%) said yes. This means the SSRS sample in the control group is selective, and not all children completed the measure. Additionally, because SSRS data was not collected at baseline, it is not possible to assess change over time or examine the extent to which relationship quality mediates changes in offending outcomes. For this reason, the SSRS analysis is descriptive and exploratory and should be interpreted with caution.

Table 23 summarises SSRS scores by group. This shows that:

- Children in the STEER group reported higher average scores than those in the signposting group on two of the positive subscales (feels valued and mentoring) and significantly lower scores on the negativity subscale.

- An independent samples t-test suggested that these differences were significant: children in the STEER group scored statistically significantly higher compared to those in the signposting group on feels valued (p < 0.001) and mentoring (p < 0.001) and significantly lower on negativity (p < 0.001).

Overall, these results are consistent with STEER's theory of change: children who received mentoring reported stronger, more trusting relationships with a supportive adult, and those who attended more sessions reported higher levels of perceived support.

Table 23. Social Support and Rejection Scale descriptive stratified by group

STEER group	N	Mean	Median	SD	SE	Skewness	Kurtosis
Feels valued	252	4.58	4.83	0.64	0.04	−2.39	7.54
Trust	252	3.63	3.60	1.02	0.06	−0.47	−0.44
Mentoring	251	4.12	4.20	0.82	0.05	−1.19	1.76
Negativity	251	1.29	1.00	0.74	0.05	3.74	14.6
Signposting group	**N**	**Mean**	**Median**	**SD**	**SE**	**Skewness**	**Kurtosis**
Feels valued	141	4.28	4.50	0.75	0.06	−1.37	2.57
Trust	140	3.43	3.40	1.03	0.09	−0.20	−0.65
Mentoring	140	3.75	4.00	0.96	0.08	−0.58	−0.23
Negativity	138	1.62	1.50	0.65	0.06	1.56	2.49

SD = standard deviation; SE = standard error

Among participants in the STEER group, an additional exploratory analysis indicated a statistically significant positive correlation[27] between the number of face-to-face mentoring sessions attended and three of the SSRS subscales:

- **Feels valued**. A modest, statistically significant correlation was observed for the feels valued subscale ($r = 0.21$, $p < 0.05$), indicating that children who attended more sessions were more likely to feel that their mentor cared about them and their progress.

- **Trust**. A slightly stronger, statistically significant correlation was observed for the trust subscale ($r = 0.23$, $p < 0.05$), suggesting that more frequent contact was associated with greater feelings of safety and trust in the mentoring relationship.

- **Mentoring**. A statistically significant positive correlation was also found for mentoring ($r = 0.19$, $p < 0.05$), showing that those who attended more sessions were more likely to perceive their mentor as someone who introduced them to new ideas, interests or experiences.

These results suggest that higher levels of engagement with STEER were associated with stronger and more supportive mentoring relationships. While this analysis does not establish a causal link between session attendance and relationship quality or between mentoring relationships and offending outcomes, it reinforces the view that relationship quality is a likely active ingredient in the STEER model. Ensuring regular, consistent engagement and minimising missed sessions may, therefore, be important priorities for maximising the programme's potential impact.

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[27] For some variables (e.g. feels valued, trust and mentoring in the SRSS), SPSS standardly only reports significance as flagged categories ($p < 0.05$ or $p < 0.01$) rather than providing exact p-values.

4 The implementation and process evaluation method

4.1 Research questions

We conducted an IPE to support the RCT by providing insights into the implementation, delivery and perceived impact of STEER. The key research questions were:

1. Dimensions of implementation: How effectively has STEER been implemented?

- **1a. Fidelity.** To what extent has support been delivered in line with STEER's theory of change and toolkit?

- **1b. Dosage:** How many sessions have been delivered to children? How many sessions need to be delivered to have an impact?

- **1c. Quality:** How well has STEER been delivered?

- **1d. Reach:** How well has STEER reached its intended cohort?

- **1e. Responsiveness:** To what extent have children engaged with the intervention?

2. Factors affecting delivery and implementation? What are the key factors which influence the successful delivery and implementation of the STEER programme? This includes:

- **2a. Local area- / community level factors:** Which factors have impacted implementation in local areas and communities, for example, level of need, availability of other services, system structures, existing referral pathways, readiness for change, and/or policy practice and funding context?

- **2b. Organisation-level factors:** Which factors have impacted implementation at the organisational level, for example, capacity, skills and training, coordination, and resources?

- **2c. Unexpected factors:** Which other factors have had an impact?

3. Experiences of support: What are children's experiences of support?

- 3a. Which aspects of STEER have supported positive outcomes?

- 3b. How have children's experiences of support differed?

4. Guidelines for future implementation

- 4a. What are the implications for future replication, scale and spread?
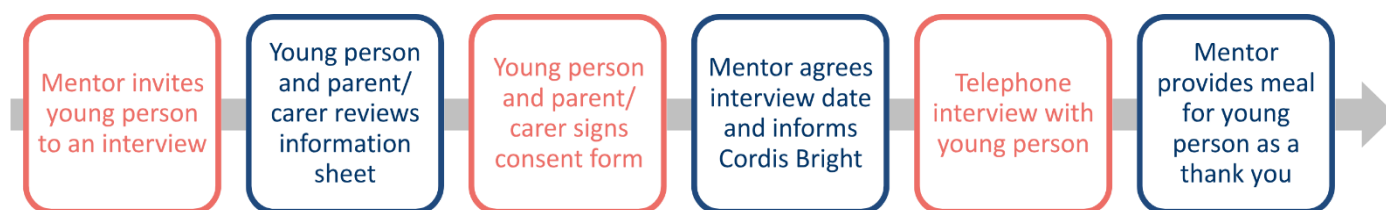
4.2 Organising interviews with children

In-depth interviews took place in November and December 2025. We worked with the Salford Foundation, including the STEER mentors, to gain informed consent from 15 children and their parents/carers in the treatment group to take part in an interview.

We asked the STEER team to identify children who were interested in taking part. Children and their parents or carers provided informed consent to take part in a telephone interview. This included working with the STEER team to identify a sample that was as representative as possible of the groups of children they were working with in terms of gender, age and ethnicity.

As highlighted in Figure 5, we employed an iterative approach in collaboration with STEER mentors to interview children who had participated in the STEER programme.

Figure 5. Process for conducting interviews with children participating in STEER

Mentor invites young person to an interview → Young person and parent/carer reviews information sheet → Young person and parent/carer signs consent form → Mentor agrees interview date and informs Cordis Bright → Telephone interview with young person → Mentor provides meal for young person as a thank you

Interviews were conducted by experienced members of the Cordis Bright research team via telephone to increase the uptake of interviews (based on our experience of what had worked well during the internal pilot study) and to minimise bias (rather than the interview being conducted by Salford Foundation colleagues, for example). Interviews were conducted by telephone, piggybacking onto children's mentoring sessions. Mentors were on hand to provide support to children as appropriate but also gave space and privacy to the children taking part. This meant that mentors were commonly in a different room/space from where the child was participating in the interview. This approach helped to ensure the smooth running of interviews and the provision of pre- and post-interview support for children. The interviewer took contemporaneous notes of the conversation, which we then stored on our secure server in a password-protected file, which was only accessible to STEER evaluation team members.

We communicated with STEER mentors ahead of interviews to ensure we had any relevant information about the child, which may impact the style and process of the interview (e.g. providing adaptations for children with SEND and/or literacy support needs). We also worked with STEER team members to ensure appropriate aftercare for interview participants following interviews.

4.3 Organising interviews with STEER staff and wider stakeholders

We worked with the Salford Foundation management team to identify a sample of STEER project staff (n = 11) and a sample of wider stakeholders (n = 10) working with or alongside the STEER programme. Wider stakeholders included representatives from partners working with the children in STEER, including representatives from the GMCA, local councils, Greater Manchester Police and youth justice services.

Once the stakeholder was nominated for an interview, the Cordis Bright research team contacted them via email, giving them more information about the purpose of the research and the interview. After consent was received, interviews were organised online (Microsoft Teams). During the interviews, we took contemporaneous notes, stored on our secure server and accessible only to research team members (i.e. they were password-protected). The majority of people invited to participate in interviews took part.

4.4 Participant characteristics

As part of the IPE, we conducted in-depth interviews with:

- Eleven STEER staff members, including referral and assessment coordinators, mentors (youth workers), and operational and leadership staff.
- Ten wider STEER stakeholders, including representatives from the GMCA, local councils, Greater Manchester Police and youth justice services. These stakeholders were chosen because of their role in supporting referrals and/or for their involvement in the STEER Strategic Steering Group.

- Fifteen children who had recently completed STEER. Table 24 provides their demographic data in comparison to the total sample of children in either the treatment or signposting groups of the efficacy study. This shows that our sample of interviews was broadly representative of those children involved in the STEER efficacy study RCT.

Table 24. ChildCharacteristics of children in the implementation and process evaluation (IPE) compared to the total sample

	IPE sample		Total sample
Ethnicity	**n**	**%**	**%**
White	12	80.0%	79.7%
Asian or Asian British	0	0.0%	3.8%
Black, Black British, Caribbean or African	1	6.7%	3.0%
Mixed or Multiple ethnic groups	1	6.7%	10.2%
Other ethnic group	1	6.7%	2.8%
Missing	0	0.0%	0.6%
Sex	**n**	**%**	**%**
Male	11	73.3%	78.2%
Female	4	26.7%	21.6%
Non-binary	0	0.0%	0.1%
Age	**M**		**M**
Age	14.3 ± 1.3		13.7 ± 1.73
SEND	**n**	**%**	**%**
No	11	73.3%	63.0%
Yes	4	26.7%	37.0%

A separate topic guide was developed for each group to explore key implementation and process research questions. We used Cordis Bright's internal Equality, Diversity and Inclusion Toolkit to ensure that all topic guides were designed through the lens of racial and cultural sensitivity and were accessible to all participants. These topic guides (see Appendix G for topic guides) were shared and refined with Salford Foundation and YEF colleagues before use.

Children have been given pseudonyms to ensure their confidentiality and anonymity.

4.5 Monitoring and activity data

In addition to the interviews, the Salford Foundation team shared monitoring data with Cordis Bright. To prevent duplicate monitoring systems, it was agreed during evaluation set-up and mobilisation that the evaluation should use the Salford Foundation's client relationship management system to monitor children's background characteristics, STEER dosage and activity. Monitoring data provided by the Salford Foundation included:

- Programme information on all children who have been referred to STEER (including numbers of referrals, accepted as eligible, consented, not consented, started, completed or dropped out)

- Background characteristics for all children who consented to be involved in the evaluation (including accommodation type, borough, children's services involvement, postcode, age, ethnicity, gender and disability)

- Activity data, including dosage of support for children in the treatment group (number of sessions and type of sessions received) and topics covered from the STEER toolkit, provided by the STEER mentors

Data was transferred to Cordis Bright by secure email (i.e. Egress) and saved on Cordis Bright's secure cloud-based server using the unique identification number assigned to each individual who consented to take part in the evaluation.

As highlighted in Section 2.7.5, Cordis Bright provided the Salford Foundation with areas for improvement in how the monitoring data was recorded during a training day in Autumn 2023. This included data accuracy and completeness, including types of activity and session topics. This was to help ensure consistent approaches were being used to record dosage and activity. It is likely that there is some under-recording of dosage and activity data. However, this cannot be independently verified. This should be considered when interpreting findings based on the monitoring data provided by the Salford Foundation.

4.6 Analysis

The qualitative evidence captured through the IPE was recorded in a matrix that mapped responses against the research questions. We deployed a mixture of a priori codes and open coding to categorise and identify recurring themes. This was an iterative process in line with the thematic analysis approach (Braun and Clarke, 2006), using initial data collected to establish themes and using these themes to continue to code further data. This allowed for constant comparison of the themes and ensured that any theories or judgements were closely linked to the data they developed from.

We also integrated the analysis of monitoring data into the IPE to support the analysis by comparing childrenpeople's, the Salford Foundation's and wider stakeholders' views with the evidence provided by the monitoring data.

Evaluation reports are strongest when a range of evidence is used to answer each evaluation question. To ensure that the data was not presented in silos, we undertook a rigorous approach to triangulating both qualitative and quantitative data. This included cross-referencing both quantitative and qualitative data against the research questions to assess how effectively the STEER programme had been implemented and the extent to which experiences of support had differed across groups.

5 Implementation and process evaluation findings

The following section provides the findings from in-depth interviews with 15 children, 11 STEER staff members and 10 wider stakeholders and the analysis of STEER monitoring data as part of the IPE (as discussed in Section 4.4). The findings have been structured in line with the research questions (as highlighted in Section 4.1):

5.1 Dimensions of implementation

5.1.1 Fidelity

This section answers the following research question(s): 1a) Fidelity: To what extent has support been delivered in line with STEER's theory of change and toolkit?

Fidelity in this instance refers to the extent to which STEER was implemented in line with its theory of change and programme toolkit.

STEER's main activities included (see Section 1.3 for more information about these activities):

- Weekly one-hour, one-to-one, in-person mentoring sessions plus an additional one hour a week of wraparound support over a period of 24 weeks (six months).

- Fourteen hours of support from a family support worker across the six months.

Mentoring support

Evidence concerning the extent to which mentoring support was delivered with fidelity is mixed. The analysis of the monitoring data suggests that children in STEER received less than the intended dosage. However, consultation with STEER staff and children suggested that delivery of mentoring was in line with the theory of change and the STEER toolkit. As part of this evaluation, it has not been possible to interrogate the difference between STEER staff views and monitoring data, as staff stakeholder interviews took place prior to the receipt and analysis of STEER monitoring data.

When interpreting the findings from the monitoring data based on the Salford Foundation's client relationship management system, caution should be applied, as there may have been issues of under-recording and differential recording by mentors. The monitoring data has also not been independently verified (see Section 2.7.5 for more information). However, it provides one source of evidence to help us understand how STEER has been delivered in relation to what was intended.

Table 25 indicates the number of STEER sessions attended by children, comparing the full sample (n = 337) with those included in the CCA (n = 257). While the programme was designed to offer 24 one-hour face-to-face sessions over a six-month period (one per week), only five children (1.5% of the full sample; 1.9% of the CCA sample) received the full intended dose. The mean dose was 14.1 (see Table 15 for more information).

The most common range – and therefore a typical dosage – was 12–17 face-to-face sessions, accounting for 35.5% (n = 120) of the full sample and 44.4% (n = 114) of the CCA sample. Attendance at five or fewer sessions was relatively common in the full sample (18.4%, n = 62), but much less so in the CCA sample (3.9%, n = 10), reflecting higher dropout or incomplete data among lower attenders.

This data suggests a dose–response pattern in retention: Children who attended more sessions were also more likely to complete follow-up measures and be included in the CCA. However, children participating in 10 or more STEER sessions were not associated with a statistically significant reduction in offending variety (as discussed in Section 3.3.6).

Table 25. The number of face-to-face sessions children attended.

The number of face-to-face sessions children had for STEER	Full sample (n = 337)		CCA sample (n = 257)	
	Frequency	Percentage	Frequency	Percentage
1	16	4.7%	1	0.4%
2	16	4.7%	1	0.4%
3	10	3.0%	2	0.8%
4	9	2.7%	1	0.4%
5	11	3.3%	5	1.9%
6	8	2.4%	5	1.9%
7	12	3.6%	7	2.7%
8	9	2.7%	7	2.7%
9	22	6.5%	17	6.6%
10	21	6.2%	16	6.2%
11	19	5.6%	19	7.4%
12	23	6.8%	22	8.6%
13	22	6.5%	20	7.8%
14	20	5.9%	18	7.0%
15	23	6.8%	22	8.6%
16	12	3.6%	12	4.7%
17	20	5.9%	20	7.8%
18	12	3.6%	11	4.3%
19	13	3.9%	12	4.7%
20	11	3.3%	11	4.3%
21	9	2.7%	9	3.5%
22	6	1.8%	6	2.3%
23	5	1.5%	5	1.9%
24	5	1.5%	5	1.9%
27	2	0.6%	2	0.8%
28	1	0.3%	1	0.4%
Total	**337**	**100.0%**	**257**	**100.0%**

CCA = complete case analysis

Table 26 shows the number of children who had recorded data for other types of support in addition to face-to-face sessions, as well as the average number of those sessions received. For face-to-face sessions, it shows that in the full sample, children received, on average, 12 sessions – in the CCA, this was an average of 14.1 sessions. The average number of sessions in both cases is well below the intended number of 24 sessions.

The table shows the next most prevalent types of support that were attempted: (1) contact/chasing up, (2) liaison with other professionals, (3) email/mail/text and (4) phone contact. These activities formed part of the wraparound support mentors offered, typically focused on trying to engage the high-risk cohort that STEER worked with.

Table 26. Prevalence and mean of session type

	Full sample (n = 337)		CCA sample (n = 257)	
	Prevalence (%)	Mean	Prevalence (%)	Mean
Face to face	100.0%	12	100.0%	14.1
Attempting contact/chasing up	87.8%	5.5	86.4%	5.5
Liaising with other professionals	58.5%	3.4	56.4%	3.6
Email/mail/text	63.8%	2.9	63.4%	3
Phone contact	59.6%	2.4	59.5%	2.5
Paper work	15.7%	1.5	17.9%	1.6
Other	3.6%	1.9	4.7%	1.9
Advocacy on the child's behalf	3.3%	1.5	3.9%	1.5
Group work	1.5%	1	1.9%	1
Accompanying the client to an appointment	1.2%	1	1.6%	1
CCA = complete case analysis				

Table 27 shows the topics mentors covered with children who received STEER. This includes the mandatory topics (as per the theory of change) and shows that not all children covered all sessions – with the most covered topics being thinking, attitudes and behaviours, and aspirations/goal setting. This also includes optional topics – also described in the theory of change – which include 59.5% of children receiving support with anger management (67.7% for children in the CCA).

There were also a number of additional topics not explicitly mentioned in the STEER toolkit. Based on the way the monitoring data was captured, there is uncertainty about which activities took place during these additional topics. For example, some of the additional topics – such as mentor–mentee relationship building – may have been ticked by mentors as an activity happening concurrently with mandatory topics being delivered. Topics such as emotional support or mental health may have come up while mandatory topics were being covered. As a result, we are unable to ascertain the potential impact these additional topics have had on children or whether the inclusion of additional topics may have affected mentors covering all mandatory topics.

Table 27. Prevalence and mean of topics covered with mentors for the full sample and complete case analysis (CCA) sample.

	Full sample (n = 337)		CCA sample (n = 257)	
	Prevalence (%)	Frequency	Prevalence (%)	Frequency
Mandatory topics				
Thinking attitudes and behaviours	76.3%	2.8	83.3	3.1
Aspirations/goal-setting	76.3%	2.5	82.5	2.6
Relationships	59.1%	2	70.0	2.1
Criminal exploitation	46.9%	1.4	57.6	1.4
Safety planning	45.1%	1.2	56.4%	1.2
Weapon carrying	43.6%	1.4	51.8%	1.4
Optional topics				
Anger management	59.6%	1.9	67.7%	2
Drugs/alcohol	29.1%	1.7	33.5%	1.7
Family support worker				
Family support offer	50.4%	2.9	53.3%	3
Additional topics				
Mentor–mentee relationship building	87.2%	4.3	90.3%	4.7
Positive activity	64.7%	3.6	75.1%	3.8
Emotional support	37.7%	2.1	41.2%	2.3
Family support from the mentor	35.3%	2.3	40.1%	2.3
Mental health	35.0%	2.2	42.0%	2.3
Safeguarding	26.1%	2.1	28.8%	2.2
Education, employment and training	25.8%	3.2	29.6%	3.4
Offending	21.7%	1.6	24.5%	1.6
Physical health	20.2%	1.6	25.3%	1.6
Risk assessment	14.5%	1.9	16.0%	2
Sexual health	9.8%	1.7	10.9%	1.8
Parenting	8.3%	1.9	10.1%	1.9
Finances	3.9%	1.2	5.1%	1.2
Housing	1.5%	1.4	1.9%	1.4
Other topics	10.4%	6.8	11.7%	6.6

CCA = complete case analysis

Whereas the monitoring data indicates that children received less of the STEER programme than intended in terms of dosage and some mandatory topics, findings from the interviews with STEER staff and children painted a more positive picture. This discrepancy may stem from inconsistencies in how mentors engaged with the customer relationship management system, making it difficult to confirm consistency across staff and over time. It may also reflect the particular sample of children we interviewed, who may have had more

positive experiences of the programme, received more of the programme than peers and/or been subject to recall bias (e.g. not remembering missed sessions or specific content covered).

STEER staff and children suggested:

- **The mentoring element of STEER was delivered in line with the theory of change and the STEER toolkit.** STEER staff reported that the programme was delivered in line with its toolkit. They stated that the STEER toolkit was key to delivering standardised and comprehensive content to children. They viewed it as being instrumental in guiding how staff are trained and in supporting STEER in delivering standardised content to children in line with the theory of change. However, some mentors suggested that they relied on it less over time as they became more familiar with the content and structure of sessions.

- **In line with the theory of change, children reported meeting with their mentors on a weekly basis for one-hour, one-to-one sessions.**

- **Children reported receiving sessions in line with the theory of change and the STEER Toolkit.** Children reported that they had received sessions on mandatory topics referenced in the theory of change and the STEER toolkit. This included covering sessions on safety planning, relationship mapping, healthy relationships, weapon carrying, attitudes, behaviours and goal setting.

- **The six-month period of STEER enabled mentors to deliver the programme flexibly to meet children's needs.** STEER mentors reported that the six-month period of STEER meant they were able to run the programme flexibly. They were able to draw on the STEER toolkit to offer a mix of mandatory and optional topics that were most needed or tailored to the child's needs. They also reported that in some instances, they could spend multiple weeks on one topic if needed.

- **The optional anger management topic was commonly delivered.** STEER mentors reported running the anger management optional topic "every time", as they found children often struggled most with this and reported that the topic worked well, as it focused on their needs and enabled them to become more open-minded. Similarly, anger management was often mentioned by children, suggesting this was an important topic and a prevalent issue among children. One mentor flagged the benefits of the anger management topic for children who were struggling with attention deficit hyperactivity disorder (ADHD) and impulsiveness.

- **Mentors reported that they were able to support children in line with outcomes in the theory of change.** Mentors stated they were able to help children improve their understanding of the risks and implications associated with their behaviours, provide information on emotional learning, make informed positive choices, think about their future and develop healthy relationships, as per the theory of change. Staff at the Salford Foundation reported collecting internal outcome data on their one-to-one mentoring, highlighting that modules on emotional regulation, understanding and managing risks, confidence, and agency surrounding decision-making were particularly effective.

- **Children reported that STEER supported them with their education, school performance, goal-setting and planning.** Children stated that STEER supported them with their education and school performance, including improving their attendance and helping them get into college to earn qualifications, which enabled them to set goals and plan better for the future – in line with STEER's theory of change focusing on improving future outcomes and goal setting for children.

Mentors suggested the following areas where the programme could improve:

- **Toolkit flexibility.** Mentors suggested that the toolkit could be developed to be more flexible to account for different learning styles; some children prefer worksheet-style resources, while others prefer a more conversational delivery. One staff member highlighted that the toolkit content was not always appropriate for all age groups, specifically those who are at the younger end of the STEER cohort.

- **Knife crime topic.** One mentor stated that they found it challenging to convey the seriousness of the topic to children. They compared it to the content in the STEER toolkit exploitation intervention, which comprised a video and discussion, and suggested that perhaps the knife crime session would benefit from further resources to improve its delivery.

- **Attitudes and behaviours content.** One mentor stated that they found the attitudes and behaviours content difficult to work with, as this was based on shifting the mindsets of children. They reported that children were often quite stubborn and resistant to this information.

Family support

Interviews with STEER staff suggested that STEER deviated from its theory of change, as the family support work was not being delivered as intended due to poor uptake. This was highlighted as a challenging area in the STEER internal pilot study report, which showed that only five out of 50 families received family support.

During the efficacy study, STEER staff reported that this aspect was the "least successful across all areas" (STEER staff), despite significant effort to roll it out in different configurations, e.g. one-to-one sessions, group sessions, face-to-face or via Teams. STEER staff members reported difficulties engaging with the wider families of children, with some parents finding it (1) challenging to work with several professionals, i.e. from STEER and from other agencies which may be supporting them, and/or (2) perceiving family support as "parent support" (STEER staff) and declining formal help.

Table 27 highlights that just over 50% of children's parents/carers took up the offer of receiving the family support – receiving on average around three sessions. This is much less than was intended in the STEER theory of change.

Although the family support element of STEER was not delivered as intended, mentors reported that, as part of the mentoring support they offered, they often fell into the informal role of offering support for parents or carers, for example, being asked for advice or guidance when picking up or dropping off a child. Staff noted that this could blur professional boundaries and add to their workload, creating a risk of burnout:

> *"Sometimes, when no external agencies are involved, [mentors are] at risk of blurring the lines between family support, and this can lead to burnout – we have to remind them [that] we're youth workers and not social workers. It's difficult because you can see the impact family work has on children".*
>
> *STEER staff*

Table 27 shows that mentors provided this type of support in around one in three cases (recorded as family support from mentor). While children did not directly comment on family support as a distinct part of STEER, some described receiving help with family relationships and home life, indicating that this informal support delivered by the mentors was reaching them.

5.1.2 Dosage

This section answers the following research question(s): 1b) Dosage: How many sessions have been delivered to children? How many sessions need to be delivered to have an impact?

Dosage refers to how much of the STEER intervention participants received and explores how many mentoring sessions have been delivered to children and how many need to be delivered to have an impact. Consultation as part of the IPE contrasts with the monitoring data analysis concerning dosage presented above (Monitoring data, highlighted in Section 5.1.1, suggests that the dosage was not met, with children attending an average of 14.1 sessions (instead of 24), suggesting that:

- **Children reported receiving the dosage as outlined in the theory of change and the STEER toolkit.** The children we interviewed reported that they met with their mentor once a week for six months, although the exact number of sessions varied depending on individual circumstances. Attendance was generally consistent; some children reported never missing a session, while others only missed sessions due to illness, mentors being on leave, or contextual factors, such as holidays or moving schools. Most children reported that the frequency and duration of the sessions were appropriate and gave them enough time to talk to their mentor, discuss their week and explain how they were feeling. However, several children said they felt sad when STEER ended and wished they could continue, suggesting that while the planned dose met expectations for many, some would have welcomed a longer mentoring period.

- **STEER staff reported delivering STEER dosage in line with the theory of change and the STEER toolkit, which, as discussed above, differs from the picture presented by the monitoring data.** However, their views on dosage and the duration of STEER were mixed in terms of whether it would achieve the desired impact. Staff members shared the following views:

  - **The six-month delivery period was a strength of STEER.** Several mentors suggested that the six-month mentoring period was a strength of STEER, particularly compared to other services that offer shorter interventions and are more limited in scope.

  - **STEER could benefit from being longer in duration.** Some mentors suggested that the programme could benefit from running for a longer period of time to allow more time to build trust with children and their families and to help achieve positive outcomes within the timeframe of the intervention. Similarly, some children we spoke to expressed a wish for more sessions, reporting that they were disappointed when their time on STEER ended.

  - **The impact of STEER may not be visible during or at the end of the six-month intervention.** One staff member suggested that the benefits of STEER may not always be visible during the six-month intervention, highlighting an example of a child previously involved in gangs who, a year later, after involvement in STEER, had qualified as a lifeguard, was attending college and was socialising more. This suggests that, for some, the programme's impact may emerge over time.

5.1.3 Quality

This section answers the following research question(s): 1c) Quality: How well has STEER been delivered?

STEER delivery was supported by its toolkit

Mentors reported that the toolkit was a successful guide to delivering STEER, and whilst not all mentors rigidly adhered to the toolkit (as highlighted in Section 5.1.1), they reported that it provided a useful structure and enabled the standardisation of programme delivery, ensuring that all children on STEER received the same information.

Mentors were given the freedom to personalise and tailor the intervention content to the child's main need or areas of concern, which supported personalisation in how the programme was delivered. Mentors' ability to adapt sessions with mentees helps ensure support is tailored and can meet the needs of each child. For some children, this meant there would have been a greater focus on optional modules that were of more relevance to their behaviours. Mentors suggested this was important to ensure children felt empowered. Children reported that they were satisfied with their weekly sessions, finding the intervention content to be relevant and beneficial.

Safe exit criteria

Staff described the exit criteria for STEER as clear and well communicated, with children being told from the outset that the programme would last six months. Mentors begin exit planning about a month before the end, including signposting to other services where needed. In some cases, mentors could have requested an extension if they felt it was appropriate, with decisions supported by the operational team, whose impartial perspective helped guide this process. While the exit process was generally seen as appropriate, one mentor raised concerns about ending support for children with ongoing needs.

Group differences

Staff described adapting STEER to meet the needs and attributes of each child. They noted that **age** could influence engagement. Younger mentees or those with a younger mental age often needed simpler, softer approaches. Older mentees could be more resistant and take longer to build trust and show changes in behaviour.

Some staff also observed potential **gender differences**, suggesting that girls tended to benefit more in terms of mental health outcomes, while boys were more likely to respond to support focused on behaviour, though boys were often less open to mental health work.

In addition, some mentors found it challenging to adapt the programme for children who are **neurodivergent**, citing limitations in the flexibility of the toolkit and a lack of confidence in how best to engage this group. Operational staff and wider stakeholders noted that this reflects a broader gap across services, highlighting the need for more training and tools to support staff in delivering interventions effectively for neurodivergent children.

Staff did not comment on any differences around **ethnicity** impacting the quality of delivering the programme. However, staff did mention adapting their approach with children and their families to meet cultural needs, gain their trust and build positive relationships. This is underpinned by employing a diverse team from a range of backgrounds. Additionally, the Salford Foundation worked closely with local community organisations, including those with specialist knowledge of global majority communities (e.g.

AFRUCA), to ensure culturally responsive support and to help overcome barriers to engagement where internal knowledge may be limited.

5.1.4   Reach

This section answers the following research question(s): 1d) Reach: How well has STEER reached its intended cohort?

Findings from the IPE suggested the following:

- **STEER reached its intended audience.** STEER is designed for 10–17-year-olds who are at risk of involvement in violent crime because they have an association with peers or family member(s) involved in serious violence, organised crime or gangs. STEER staff and wider stakeholders generally agreed that STEER successfully reached this target group across its delivery areas. STEER was seen to address an earlier prevention support gap through mentoring, which is not widely available across Greater Manchester. Furthermore, wider stakeholders commented on the eligibility criteria being broader than those of other services, supporting referrals into STEER during multi-agency prevention meetings.

- **STEER's reach varied across the six boroughs of Greater Manchester**. STEER was first rolled out in Wigan and Trafford and later expanded into other areas of Greater Manchester, including Bolton, Manchester, Tameside and Salford. Staff reported that roll-out in Wigan, Bolton and Salford benefited from the Salford Foundation's strong local reputation, resulting in steady or high referral rates. By contrast, referrals were initially slower in Trafford and Manchester, partly because STEER was a new service and less established locally. In Tameside, external challenges within the local authority also affected early take-up. Staff reported that STEER was rolled out in Bolton towards the end of the YEF funding period, which accounts for the lower numbers in this area. Table 28 shows the number of children reached in each borough.

- **Variation in reach by gender.** Table 28 shows that the proportion of girls who were randomised into the efficacy trial ranged from 11.0% in Tameside to 27.6% in Wigan. Consultation with STEER staff suggested that referrals for girls were initially low, but this improved over time, with girls accounting for about a quarter of referrals. Staff noted that schools often referred boys for aggressive behaviour, with their concerns being outwardly present. In comparison, recognising the needs of girls – who may benefit from STEER – can be more challenging, especially in younger girls. As a result, staff reflected that some girls may have been missed.

Table 28. Age of children randomised in the efficacy study (n = 689), stratified by Greater Manchester borough

Gender	Bolton	Manchester	Salford	Tameside	Trafford	Wigan
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Male	20 (80.0%)	103 (76.3%)	96 (82.0%)	96 (88.1%)	59 (78.7%)	165 (72.4%)
Female	5 (20.0%)	32 (23.7%)	21 (18.0%)	12 (11.0%)	16 (21.3%)	63 (27.6%)
Non-binary	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.9%)	0 (0.0%)	0 (0.0%)
Total	**25**	**135**	**117**	**109**	**75**	**228**

- **Variation in reach by minority ethnic background.** Staff suggested that STEER's ability to work with people from diverse groups was supported by being able to draw referrals from multiple sources – including schools, multi-agency referral arrangements (e.g. PIED), other organisations and families – to reach those at risk. One staff member expressed uncertainty about how effectively the programme reaches multicultural communities, noting that in some areas, certain minority groups may be overrepresented, while in others they may be underrepresented.

    Table 29 below compares the percentage of the population from ethnic minority groups in each of the participating Greater Manchester boroughs from Census 2021 data (Office for National Statistics, 2021) with children randomised in the efficacy study. This table shows a potential under-representation of ethnic minority groups reached by STEER in Manchester and Trafford when comparing with Office for National Statistics data for 10–18-year-olds.

- **Reasons for variations in reach by ethnic minority background.** STEER staff noted a challenge in maintaining a good rate of referrals from diverse communities in areas where other similar services were present. For example, in Manchester, there was a similar service being delivered specifically to support Black and ethnic minority communities. During multi-agency meetings (i.e., PIED and Engage), when referrals were discussed, this often meant referrals for Black and ethnic minority children were sent to AFRUCA instead of STEER. Similarly, the reach of STEER may have been impacted by other services (e.g., Remedi's restorative mentoring service) and by the introduction of Turnaround,[28] a statutory prevention service for all youth justice services in England and Wales.

The presence of similar services to STEER in areas in which it was operating also has implications for estimating the impact of STEER in comparison to children who were in the signposting group receiving BAU, i.e. children in the control group may have been in receipt of similar services to STEER, which the evaluation did not have the resources to effectively monitor.

Several factors were seen as supporting STEER's ability to engage its target audience. These included:

- **Early promotional work.** This included going into schools and attending multi-agency panels that included partners such as Greater Manchester Police, to explain what the Salford Foundation does and what the STEER programme is. Wider stakeholders commented on how the strategic leadership team, operational lead and youth workers at the Salford Foundation promoted STEER, meaning that decision makers and those actively putting in referrals received information about the programme, which supported buy-in and reach.

- **Employing mentors with strong local knowledge** helped build trust and awareness of STEER with referrers, children and families. For example, by hiring mentors from specific areas, STEER was able to expand into new regions, such as Tameside, effectively.

- **Employing mentors who are relatable.** Some staff and stakeholders described the benefits of STEER mentors being relatable to children – such as being closer in age, sharing lived experience or reflecting the communities they work in – as an essential factor in building rapport and trust.

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[28] The Turnaround programme is a youth early intervention programme led by the Ministry of Justice, which started in December 2022. For more information, see here.

Table 29. Comparison of ethnicity for children randomised in the efficacy study (n = 689) and 2021 Census data for 10–18-year-olds, stratified by Greater Manchester borough

Ethnicity	Bolton Efficacy study n (%)	Bolton Census %	Manchester Efficacy study n (%)	Manchester Census %	Salford Efficacy study n (%)	Salford Census %	Tameside Efficacy study n (%)	Tameside Census %	Trafford Efficacy study n (%)	Trafford Census %	Wigan Efficacy study n (%)	Wigan Census %
White	21 (84.0%)	59.5%	75 (55.6%)	39.6%	97 (82.9%)	77.4%	75 (68.8%)	78.5%	65 (86.7%)	67.1%	216 (96.4%)	92.9%
Asian or Asian British	1 (4.0%)	27.6%	9 (6.7%)	25.8%	4 (3.4%)	5.5%	1 (0.9%)	13.1%	4 (5.3%)	17.6%	1 (0.5%)	1.9%
Black, Black British, Caribbean or African	0 (0.0%)	6.4%	16 (11.9%)	19.1%	5 (4.3%)	8.4%	6 (5.5%)	3.3%	0 (0.0%)	4.1%	0 (0.0%)	1.7%
Mixed or Multiple ethnic groups	0 (0.0%)	4.3%	26 (19.3%)	8.7%	9 (7.7%)	5.0%	26 (23.9%)	4.4%	5 (6.7%)	7.6%	4 (1.8%)	2.8%
Other ethnic group	3 (12.0%)	2.3%	9 (6.7%)	6.8%	2 (1.7%)	3.7%	1 (0.9%)	0.7%	1 (1.3%)	3.6%	3 (1.3%)	0.8%
Missing	0		0		0		0		0		4	
Total	25 (100%)		135 (100%)		117 (100%)		109 (100%)		75 (100%)		228 (100%)	

Note. Missing values have not been included in percentages.

5.1.5 Responsiveness

This section answers the following research question: 1e) Responsiveness: To what extent have children engaged with the intervention?

Children's feedback suggests that overall, engagement with STEER was strong and positive. They consistently reported attending most sessions, found the content relevant and accessible, and described their mentors as trustworthy, relatable and easy to talk to. Children said the sessions helped them work towards personal goals, such as managing anger, improving at school, building confidence or staying away from risk-taking behaviours.

Several factors were highlighted as supporting this engagement:

- **Clear onboarding.** Children said they received useful information at the start of STEER, both through schools and home visits from Salford Foundation staff, which helped set expectations.

- **Flexibility**. While the programme is structured around a toolkit, mentors tailored content to meet individual needs. For example, anger management content was delivered regularly, responding to common challenges children were experiencing, such as impulsiveness and ADHD.

- **Safe and trusted relationships.** Children valued having a mentor they could trust and talk to openly. They stated that mentors understood their perspective and circumstances and could speak to them on their level. As one child put it:

    "She is easy to talk to; she listens; that is what I needed – I definitely trust her and would go to her for help".

    Callie, a 15-year-old, White British girl

- **Relatability of mentors.** Wider stakeholders and staff described the age, background and approach of mentors as a magic ingredient for building trust and supporting participation.

While engagement was high for those who stayed on the programme, staff noted that some children disengaged early on, often because they felt overwhelmed by involvement with multiple professionals or because they decided that STEER was not right for them at that time. Staff suggested this tended to happen early in the programme. This suggests a potential role for clearer communication with referring partners and families to help children understand what to expect when starting STEER.

5.2 Factors affecting delivery and implementation

This section answers the following research questions: 2) Factors affecting delivery and implementation: What are the key factors which influence the successful delivery and implementation of the STEER programme?

a. Local area- / community-level factors: Which factors have impacted implementation in local areas and communities, for example, level of need, availability of other services, system structures, existing referral pathways, readiness for change, and/or policy practice and funding context?

b. Organisation-level factors: Which factors have impacted implementation at the organisational level, for example, capacity, skills and training, coordination, and resources?

5.2.1 Local and community-level factors

This section outlines local and community-level factors that influenced the implementation and delivery of STEER. Table 30 summarises key enablers identified by staff and stakeholders that supported successful delivery.

Table 30. Key local and community-level factors enabling successful implementation and delivery.

Success factor	How this factor supported successful implementation and delivery
Strong local reputation and trusted relationships	The Salford Foundation's long-standing presence and delivery of other services in Salford and the Greater Manchester area made referrals and delivery smoother. This was noticeable in Salford, Wigan, Trafford and Bolton, with staff and stakeholders saying the programme worked best initially in areas where the Salford Foundation was already known and trusted. In newer areas (e.g. Manchester), where prior links with local schools and services were weaker, stakeholders were initially hesitant, and building trusted relationships took time.
Partnership working and presence on multi-agency panels	Wider stakeholders valued the Salford Foundation's involvement in local panels (e.g. prevention panels such as Engage and Prevention, Intervention, Education and Diversion [PIED]), saying this increased visibility and built trust, which helped streamline referrals.
Strategic Steering Group supporting scale and spread	Having representation from boroughs – including prevention panel members – on the STEER Strategic Steering Group has helped establish strong partnerships and increased knowledge and awareness of STEER across areas. These meetings provide updates on referrals across Greater Manchester and facilitate strategic discussions, including how to better reach minoritised and marginalised groups. This strategic group helped support the scale and spread of STEER following the internal pilot study.
Understanding and tailoring delivery to the local context	Wider stakeholders and STEER staff reported that the team's understanding of the local context and key issues in each area supported the implementation and scale-up of STEER at pace towards the start of the efficacy study, i.e. after the internal pilot study report. This included adapting mentoring content to local needs and showing responsiveness to place-based differences.
Clear referral pathways	Where partnerships were strong and referral pathways well-established (e.g., Salford and Wigan), referrals were steady. In newer areas for STEER, such as Manchester, referrals were initially slower but improved once relationships were built. These insights echoed those in the internal pilot study report, in which wider stakeholders demonstrated a sound understanding of the eligibility criteria for STEER.
Level of need and demand	There was high demand in most areas, with stakeholders describing STEER as filling a gap, particularly for early intervention.

Success factor	How this factor supported successful implementation and delivery
Ability to reach diverse children	Whilst each borough has a different demographic make-up of children, STEER reached a wide range of children through broad yet clear, inclusive and effective referral pathways, which enabled STEER staff to see children as quickly as possible. Attending local authority prevention panels helped STEER build a stronger local presence, ensuring the right individuals were being referred into STEER.

5.2.2 Organisation-level factors

This section outlines organisation-level factors that influenced the implementation and delivery of STEER.

The scale-up of STEER to new areas following the internal pilot study and during the early period of the full efficacy study presented challenges related to staffing, relationship-building and adapting delivery to local contexts. Staff described the challenge of recruiting and training new mentors in unfamiliar areas, particularly where the Salford Foundation had limited prior presence. They reported the organisation worked hard and that it took time to build trust with local partners and raise awareness of STEER, especially in areas with similar existing provision.

Staff emphasised the importance of understanding the local context, avoiding duplication with other services and allowing sufficient lead-in time to embed STEER effectively. These challenges decreased over time. However, delivery at pace was described as operationally demanding, particularly in the context of an RCT. The fact that the Salford Foundation achieved this scale-up so rapidly in the context of an RCT is a considerable achievement.

Table 31 summarises key enablers identified by staff, wider stakeholders and children that supported the successful delivery and implementation of STEER.

Table 31. Key organisation-level factors enabling successful implementation and delivery

Successful factor	How did this support successful implementation and delivery
Strong team culture and working environment	The Salford Foundation fosters a supportive, cooperative working culture, focused on recruiting the right people who are well-trained, well-supported and reflective of local communities.
Skilled and relatable mentors	Mentors are flexible and creative and build informal, trusted relationships with children. Children valued being able to speak openly with mentors who understood their backgrounds and communicated in a relatable, informal way.
High-quality toolkit	Staff valued the STEER Toolkit as comprehensive and practical and used it to structure sessions and train new staff. It was described as "one of the strongest physical pieces we've had for our projects" (STEER Staff).

Successful factor	How did this support successful implementation and delivery
Staff's ability to navigate local referral systems	Staff described referral pathways as broad but well-defined. Attendance at multi-agency prevention panels (such as Prevention, Intervention, Education and Diversion [PIED] and Engage) helped referrals into STEER. The Salford Foundation worked closely with local stakeholders to embed STEER into existing systems, including by adapting referral processes to align with those already used in PIED and Engage meetings. This approach encouraged professionals to refer to STEER by offering a more streamlined and time-efficient process.
Advocacy for children	Mentors acted as advocates for children, helping to support their wider goals, such as engagement in education, training, employment or community activities. They also acted as bridges between children, families and schools.
Ability to build trusting relationships with partners	Staff and stakeholders highlighted that the Salford Foundation's proactive efforts helped to build local relationships, strengthen community presence and support programme uptake.

5.2.3   Additional and unexpected factors impacting the delivery of STEER

This section outlines additional and unexpected factors that staff and stakeholders reported as influencing delivery. These included the complexities of participating in an RCT, variability in partner engagement and systemic issues linked to short-term funding:

- **The challenges of implementation and delivery in the context of an RCT.** Similar to the internal pilot study report's findings, staff and stakeholders reflected that participating in the efficacy RCT brought added complexity, particularly in communicating randomisation to children and their families. While the Salford Foundation had clear processes in place to explain the random allocation process, some families expressed frustration when they were allocated to the signposting group. Similarly, some referrers were reluctant to refer children into the trial, knowing that not all would access STEER. Wider stakeholders suggested that this reduced engagement from some partners, particularly in the early stages of delivery. Despite these challenges, staff worked to ensure children in the signposting group received information about alternative services, as outlined in the trial protocol and evaluation handbook,[29] which Cordis Bright co-developed with the STEER team before the RCT launched.

- **Variability in partner engagement.** Staff reported that engagement from key partners – such as schools, families and social workers – varied between areas and could directly impact referral numbers. Where partner organisations in some areas were experiencing internal pressures or were sceptical of STEER, this could reduce children's likelihood of being referred to STEER.

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[29] The evaluation handbook for the STEER team included information on (1) introducing the evaluation, (2) summary of pathways through STEER, (3) informed consent, (4) questionnaires and (5) randomisation.

- **The challenge of short-term funding.** Towards the end of the efficacy study, staff and wider stakeholders highlighted concerns about uncertainty in funding. Wider stakeholders mentioned there may be a pause on referrals during this period, which may make it harder to secure long-term buy-in from partners and create operational pressures around staff retention and the continuity of delivery for the Salford Foundation.

5.3   Children's experiences of support and outcomes

This section answers the following research questions: 3) Experiences of support: What are children's experiences of support? Including: 3a) Which aspects of STEER have supported positive outcomes? and 3b) How have children's experiences of support differed?

Across interviews, children described consistently positive experiences of STEER. They particularly valued the trusting relationships they built with their mentors, the regularity of weekly support, the flexibility around session settings and the personalised nature of sessions. Key findings included:

- **Trusting relationships between mentors and children.** Children valued having a relatable mentor to talk openly with, receive tailored advice from and set personal goals with.

- **Children spoke positively about the relationships with their mentors.** They appreciated having a relatable mentor who they trusted, who they could talk openly with, who listened without judgement, who understood their circumstances and who provided tailored advice and helped set personal goals. These findings mirrored those in the internal pilot study report, with staff and children reporting positive relationship-building between children and their mentors. Children highlighted the importance of feeling able to speak openly, noting that their mentors treated them informally, and as equals, rather than as professional figures.

> *"She gave me advice on how to make things better … it was having an adult (not my mum) who had experienced things and gave practical advice".*
>
> *Callie, a 15-year-old, White British girl*

- **The value of routines and consistency in mentors.** The weekly structure of STEER was seen as a key strength. Children appreciated having a consistent point of contact and the routine of regular check-ins, often describing sessions as something they looked forward to each week.

- **Personalised and flexible mentoring.** Children highlighted the flexibility of STEER mentoring, where sessions focused on issues most relevant to them, such as anger management and emotional control. The STEER approach made them feel understood, supported their progress and gave them someone consistent to turn to for help.

- **Mentoring took place in settings children found comfortable.** Children valued the informal settings in which STEER sessions were delivered. Sessions most commonly took place at school or at home, but some children preferred meeting in community settings, such as cafés. They appreciated having a say in where sessions were held, which helped them feel more relaxed and receptive.

- **Appreciation of the flexible and personalised approach to mentoring.** Children reflected positively on the flexible and personalised approach to mentoring. They described sessions being adapted to their individual needs and interests, with the flexibility to focus on topics that felt most relevant to them.

When asked if there were aspects of STEER they would like to change, children generally struggled to identify improvements. Some children who had finished the programme expressed sadness that sessions had ended and wished they had lasted longer. One child reflected that they wished they had opened up more during sessions, realising how useful it was only after the programme had finished.

5.3.1   Positive outcomes

Children, staff and wider stakeholders described a range of positive outcomes from participation in STEER. As highlighted in Figure 6, children's reported benefits from taking part in STEER included improved emotional regulation, increased confidence, stronger relationships with family and school, reductions in risk-taking behaviours and greater consideration of their future. All of which align with the theory of change short-term outcomes (see Section 1.3.1). Stakeholders described STEER as a meaningful early intervention for children at risk of disengagement or criminal involvement. The key component supporting these benefits was the ability to talk to their mentors on a weekly basis.

Figure 6. Childrens' perceived benefits of taking part in STEER

Relationships with family members and school staff.

Confidence and self-esteem.

Behaviour and attitudes - understanding consequences of actions.

Emotional control and anger management.

Engaging in education and employment pathways.

Changes to friendship groups.

The children we spoke to commonly reported improvements in managing their emotions, feeling less angry, increased confidence and more positive relationships with family, school and peers through participation in STEER . Several said they were in less or no trouble since working with their mentors and described greater awareness of consequences and their future goals. One child reflected:

> *"It definitely got easier to manage emotions … before, I was angry all the time; now, it's easier to control it and hold it back. Talking about it every week and building trust really helped. I feel more positive about myself and the people around me."*
>
> *Keiran, a 14-year-old, White British boy*

Some children expressed greater ambition in education or employment, such as attending college or starting an apprenticeship, which they attributed to STEER. Others, however, reported mixed feelings about the future, including a reluctance to think about it after the programme ended.

While the children we spoke to were relatively positive about the impact STEER had on their outcomes, it may be the case that children in the control group also experienced similarly positive outcomes. However, we did not speak to the children in the control group as part of this study.

Staff reinforced children's views, mentioning improvements in self-esteem, confidence, trust in services and engagement in education or employment pathways as a result of involvement in STEER. They also emphasised the role of mentors in mediating between children and their families or schools, supporting school reintegration and aiding in conflict resolution. Staff noted improvements in children's pro-social attitudes and reductions in risk-taking behaviours, though educational outcomes varied, depending on the school setting.

Wider stakeholders similarly reported that STEER strengthened children's connections to education and community services, contributing to improved long-term opportunities. They valued the relational approach and reported high levels of trust in the Salford Foundation as a delivery partner, seeing STEER as a key part of local early intervention pathways.

Some stakeholders cited local data that suggested reductions in re-offending, with one noting that the majority of children referred into STEER did not return to prevention panel processes. Children also reported getting in trouble less, being more aware of the consequences of their actions and having a stronger focus on personal goals and future aspirations.

All children interviewed said they would recommend STEER to others, citing benefits such as improved confidence, better anger and behaviour management, enhanced well-being, and having someone to listen and offer guidance to help them stay on track.

5.4 Lessons from STEER

This section answers the following research question: 4) Guidelines for future implementation: What are the implications for future replication, scale and spread?

Drawing on reflections from staff and stakeholders, several key considerations emerged to support successful replication and scale-up.

- **Early engagement and embedding in local systems.** Staff and stakeholders emphasised that for a programme like STEER to be successfully replicated, it is crucial to invest time in building the organisation's reputation and embedding the programme within local systems. The Salford Foundation's successful expansion was underpinned by early engagement with local stakeholders, participation in multi-agency panels (e.g., PIED and Engage) and alignment with local referral pathways. These aspects helped ensure STEER was seen as a trusted and complementary offer rather than a duplication of existing services.

- **Revisiting and strengthening the theory of change.** As the family support work was not delivered as intended due to poor uptake by families (as mentioned above), revising the theory of change would help assess whether the current delivery model, excluding family support, would support the delivery of STEER's intended outcomes or whether adjustments in how the family support model is delivered/implemented as part of STEER are needed to support it to deliver its intended outcomes.

  This review could also consider whether the length and intensity of STEER remain optimal. The programme offers weekly one-to-one mentoring over six months, which was broadly viewed as sufficient by staff and aligns with the YEF guidance on mentoring (Gaffney, Jolliffe, and White, 2022), which suggests mentoring programmes work best when they are at least six months in length. However, some children expressed sadness at the programme ending and a desire for longer-term support. While weekly sessions were viewed positively, there were occasional reflections that six months felt too short, suggesting value in exploring whether a longer overall duration and intensity could further strengthen engagement and outcomes.

- **Reviewing the focus and flexibility of the Toolkit.** While staff valued the Toolkit, some reflected on challenges adapting it for specific groups, such as younger or neurodivergent mentees. Similar reflections were raised when delivering STEER to the age of children (10-17 years old), suggesting a

need to simplify the content for younger mentees. Future iterations of STEER could benefit from reviewing the content, flexibility and adaptability of the Toolkit, ensuring it remains responsive to the diverse needs of children while maintaining programme consistency.

- **Prioritising skilled, relatable and diverse staffing.** One of the most consistently cited success factors was the quality of STEER's mentors, described by children as relatable, understanding and trustworthy. Recruitment of a diverse, locally representative and well-trained workforce should be central to future replication. Mentors' ability to build trusting relationships, communicate informally and adapt to children's needs was consistently identified as a key driver of engagement and positive outcomes.

6   Cost information

This section presents an analysis of the costs of delivering the STEER programme. Our approach is in line with our efficacy study protocol and YEF cost reporting guidance.

As outlined in our protocol, the analysis is based on the Salford Foundation's programme budget for STEER and discussions with key Salford Foundation stakeholders.

Our approach:

- **Estimates the costs of delivery only.** The Salford Foundation has been delivering the STEER programme in line with the programme budget, and, therefore, the budget is representative of the costs of delivery only.

- **Derives estimates using the bottom-up principle.** The Salford Foundation reported that the STEER budget was drawn up via a bottom-up approach. This means that using the STEER budget to capture the cost of delivery alongside conversations with the STEER team follows the bottom-up principle.

- **Estimates the cost from the perspective of the Salford Foundation, which is delivering the intervention.** The Salford Foundation is responsible for the delivery of STEER. It works with other organisations (e.g. schools) and through multi-agency meetings. However, working with programmes like STEER sits within the remit of those organisations.

- **Estimates the cost of resources used to deliver the intervention and does not capture how costs changed compared to BAU.** The cost estimate is representative of the resources used in the delivery of STEER and does not compare costs to BAU.

As set out in the efficacy study protocol and in line with YEF analysis guidance and YEF cost reporting guidance, we have used the following approaches to report cost information:

- All costs relating to both the evaluation and programme development/adaptation are excluded from cost estimates.

- All costs have been adjusted to constant prices for the year 2024–25 using GDP deflators. This accounts for any data around cost being collected at different points across the internal pilot and efficacy study periods. We have not discounted cost estimates based on time preferences.

- There are no durable inputs with benefits to those outside the project.

- In line with YEF cost reporting guidance, all cost estimates have been generated assuming full compliance (i.e. that all participants received the full STEER dosage – 24 hours of one-to-one support and 24 hours of wraparound support) and that their parents/carers received 14 hours of family support over a six-month period. We have provided estimates on the basis of mentors and team leaders operating at full capacity, i.e. mentors have the capacity to work with 13 children over a six-month period, and team leaders have the capacity to work with 10 children over a six-month period. We have used the staffing profiles in Table 32 to inform cost estimates.

- We have identified estimates as set-up and recurring costs. We also set out what needs to be in place concerning pre-requisite costs – in line with YEF cost reporting guidance, we have not monetised

these. Given the nature of STEER, the distinction between what is a set-up cost and what are recurring costs can be blurred. Where cost lines contain elements of both, we have noted this.

- We present estimates for two six-month periods of the STEER programme. This is because STEER scaled up following the internal pilot period, from delivery in two Greater Manchester boroughs (Wigan and Trafford) to six Greater Manchester boroughs (Salford began in July 2023, followed by Manchester and Tameside in August 2023, and Bolton in May 2024).

- In addition, recruitment into STEER was on a rolling basis. STEER is not an intervention that has starting and end points for defined cohorts; rather, participants started and ended STEER on a weekly basis throughout the programme period. The periods we have provided estimates for are for six months during the first year of delivery (October 2022–March 2023) and the second year of delivery (October 2023–March 2024). This reflects periods when STEER was up and running during the first year and when STEER had scaled up its delivery to six boroughs during the second year. Two sets of estimates like this provide insights into the potential costs for implementing STEER in either two boroughs or six boroughs, with associated differences in delivery team size and shape (see Sections 1.7 and 1.8 for more information on team shape and size across these periods).

The following sets out pre-requisite costs, set-up costs and recurring costs for STEER. This is then followed by a presentation of the total and average per-participant cost estimates for the STEER programme.

6.1 Pre-requisite costs

In line with YEF cost reporting guidance, the following lists what is expected to be in place already before the STEER programme is implemented. YEF cost reporting guidance suggests these are things that can be assumed not to need to be paid for by a funder/commissioner; as such, we have not provided costs for them. The list of pre-requisite costs includes:

Provider pre-requisite costs

It is anticipated that for an intervention like STEER to be implemented, it would require a public, private or Voluntary, Community and Social Enterprise Sector (VCSE) organisation, such as the Salford Foundation, to deliver it. This organisation would need to have in place the following things that would be pre-requisite costs:

- **Premises and offices.** Associated costs could include rates, maintenance, utilities and depreciation.

- **Strategy and governance.** Associated costs could include audit fees, board expenses, membership subscriptions, consultancy costs, travel and subsistence.

- **Support.** Associated costs could include human resources support, bank charges, payroll processing, marketing, staff recruitment, insurance and staff meetings.

- **Indirect staffing.** Associated costs could include strategy, finance, information technology, communications and business development.

It is also anticipated that the provider would have in place staff with an appetite and the ability to lead the implementation of STEER.

Wider system pre-requisite costs

It is anticipated that the wider system has the appetite, can see the need for and has the capacity to support the implementation of a programme like STEER. Costs to the system of implementing STEER include time from key stakeholders (e.g. referrers and schools), premises (e.g. rooms for mentoring) and attendance at multi-agency meetings. These are all activities that have an element of cost but form BAU activity for public sector organisations that would work with the STEER provider to support its implementation in a local system.

6.2 Set-up and recurring costs

Set-up costs occur at the beginning of the intervention. Recurring costs are ongoing. For STEER, many of the set-up costs are also recurring, as shown in Table 32.

Table 32. List of items included in cost estimates

Category	Set-up or Recurring	Description
Staff		
Delivery staff (combined)	Recurring	**October 2022–March 2023:** • Operational manager (0.4 FTE) • Project manager (1 FTE) • Mentors (2.6 FTE) • Referral and assessment coordinators[30] (0.25 Oct–Dec; 0.5 FTE Jan–Mar • Family support worker (0.8 FTE) **October 2023–March 2024:** • Operational manager (0.4 FTE) • Project manager (1 FTE) • Mentors (6.6 FTE) • Team leaders (1.8 FTE) • Referral and assessment coordinators[23] (1 FTE Oct–Dec; 1.25 FTE Jan–Mar) • Family support worker (0.8 FTE)
Clinical Supervision Costs	Recurring	Additional support staff not in-house
DBS checks	Set-up and recurring	Staff DBS checks to work with children
Staff recruitment costs	Set-up and recurring	Staff recruitment costs
Phones and Broadband	Recurring	Staff phones and internet access to contact children
Quality accreditations	Recurring	The Matrix Standard is the Department for Education's standard for ensuring the quality of the delivery of information,

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[30] Please note, the referral and assessment coordinator's time has been reduced to 50% to account for the time they spent meeting with young people in the signposting group.

Category	Set-up or Recurring	Description
Staff		
		advice and guidance for services with children. It helps providers improve their services by benchmarking against best practice, and it offers accreditation to those who meet the full standard.
IT systems (e.g. Microsoft 365)	Recurring	Staff subscriptions to Microsoft 365.
Staff training	Set-up and recurring	Training for staff (e.g. data Protection and safeguarding), including external and bespoke training
Programme		
Programme activities	Recurring	Activities with children (e.g. leisure centre, bowling and food)
Programme travel and subsistence	Recurring	Collecting children and driving to activities/venues
Parking	Recurring	Staff parking when with children
Programme postage	Recurring	Sending children and families information and/or resources
Materials and equipment		
IT hardware	Recurring	Staff laptops and tablets for children to complete forms and surveys
IT software	Recurring	Customer relationship management software
Photocopier	Recurring	Printing programme resources for children
Minor equipment	Recurring	Staff mobile phones
Additional equipment	Recurring	Stationery and other office purchases
Incentives		
Beneficiary other costs	Recurring	Food vouchers for struggling families
Buildings and facilities		
None	N/A	N/A

FTE = full-time equivalent; IT = information technology; DBS = Disclosure and Barring Service

6.3 Summary of cost estimations

Figure 7 provides a summary estimation of the cost[31] of delivering the STEER programme for six months for the following periods:

- Year 1: October 2022–March 2023

- Year 2: October 2023–March 2024.

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[31] Please note, we have not presented these as set-up and recurring costs due to the challenge of costs falling into both categories.

Figure 7. Summary total cost estimations for delivering STEER

Year 1: October 2022 - March 2023 presented in 2024-25 prices		Year 2: October 2023 - March 2024 presented in 2024-25 prices	
Total costs = £93,887.51	Cost per child = £2,868.31	Total costs = £165,974.66	Cost per child = £1,614.04

We have applied GDP deflators to show the costs of delivery in 2024–25 prices, i.e. to account for inflation between 2022–23 and 2024–25, in line with YEF cost reporting guidance. We have used GDP deflators at market prices for financial years, as presented in the GDP deflators at market prices and money GDP June 2025 (Quarterly National Accounts). Figure 8 shows the calculation for how these price adjustments have been made.

Figure 8. GDP deflators used for the presentation of cost estimates at 2024–25 constant prices

GDP Deflator (index): 2022/2023 = **90**	GDP Deflator (index): 2023/2024 = **96**	GDP Deflator (index): 2024/2025 = **100**

Change in prices: 2022/2023-2024/2025 = 100 / 91 = 1.0989 = **9.89%**	Change in prices: 2023/2024-2024/2025 = 100 / 96 = 1.0417 = **4.17%**

6.4 Detailed breakdown of cost estimations for STEER for October 2022–March 2023

Table 33 provides a summary of the STEER mentoring intervention's estimated costs for a six-month period (October 2022 to March 2023). While data collection formally started in May 2022 due to slow uptake of referrals and reduced staff rates, the programme was not fully embedded until October 2022. Total costs are estimated at £94,654.11 for delivery to 33 children (whereby each full-time mentor at capacity can support 13 children). This is equivalent to £2,868.31 per child taking part in STEER, at 2024–25 constant prices. This includes a price adjustment of 9.89% to account for GDP deflators, as highlighted in Figure 8. The largest driver of cost was delivery staff (including the management team overseeing the intervention and youth workers).

Table 33. Estimated real cost of delivering STEER for October 2022–March 2023 (delivered by the Salford Foundation), presented at 2024–25 prices.

Category	Set-up or recurring	Total
Staff		
Delivery staff (combined)	Recurring	£71,068.71
Clinical supervision costs	Recurring	£5,073.07
DBS checks	Set-up and recurring	£54.51
Staff recruitment costs	Set-up and recurring	£438.01
Phones and broadband	Recurring	£1,174.34
Quality accreditations	Recurring	£251.11
IT systems (e.g. Microsoft 365)	Recurring	£1,576.31
Staff training	Set-up and recurring	£1,003.66
Programme		
Programme activities	Recurring	£2,805.57

Category	Set-up or recurring	Total
Programme travel and subsistence	Recurring	£4,397.98
Parking	Recurring	£14.62
Programme postage	Recurring	£19.78
Materials and equipment		
IT hardware	Recurring	£4,397.80
IT software	Recurring	£1,318.68
Photocopier	Recurring	£401.30
Minor equipment	Recurring	£233.07
Additional equipment	Recurring	£425.61
Totals		
Total cost		£94,654.11
Number of children supported [32]		33
Cost per child		**£2,868.31**

DBS = Disclosure and Barring Service; IT = information technology

6.5   Detailed breakdown of cost estimations for STEER for October 2023–March 2024

Table 34 below provides a summary of the STEER mentoring intervention's estimated costs for a six-month period (October 2023–March 2024). Total costs are estimated at £166,246.96, at 2024–25 prices, for delivery to 103 children (whereby each full-time mentor, at capacity, can support 13 children, and each full-time team leader, at capacity, can support 10 children due to management responsibilities). This is equivalent to £1,614.04 per child taking part in STEER. This includes a price adjustment of 4.17% to account for GDP deflators, as highlighted in Figure 8. The largest driver of cost was delivery staff (including the management team overseeing the intervention and youth workers).

Table 34. Estimated real cost of delivering STEER for October 2023–March 2024 (delivered by the Salford Foundation), presented at 2024–25 prices.

Category	Set-up or Recurring	Total
Staff		
Delivery staff (combined)	Recurring	£136,750.26
Clinical supervision costs	Recurring	£4,972.53
DBS checks	Set-up and recurring	£211.67
Staff recruitment costs	Set-up and recurring	£471.66
Phones and broadband	Recurring	£2,189.06
Quality accreditations	Recurring	£468.10
IT systems (e.g. Microsoft 365)	Recurring	£2,938.35

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[32] This number is based on the maximum capacity for Mentors (i.e. 2.6 x 13 young people). We have rounded this down from 33.8 as a child cannot be partially supported. During this period, the STEER team did in fact support 33 young people.

Category	Set-up or Recurring	Total
Salford Foundation staff training	Set-up and recurring	£113.34
Programme		
Programme activities	Recurring	£5,014.76
Programme travel and subsistence	Recurring	£5,915.78
Parking	Recurring	£61.67
Programme postage	Recurring	£24.48
Materials and Equipment		
IT hardware	Recurring	£4,168.88
IT software	Recurring	£1,250.04
Photocopier	Recurring	£748.05
Minor equipment	Recurring	£81.02
Additional equipment	Recurring	£793.38
Incentives		
Beneficiary other costs	Recurring	£72.92
Totals		
Total costs		£166,245.96
Number of children supported[33]		103
Cost per child		**£1,614.04**

DBS = Disclosure and Barring Service; IT = information technology

6.6   Interpretation

This analysis provides estimates for the costs involved in delivering STEER across two areas, in comparison to six areas. We have presented a cost analysis for STEER to show the economies of scale that were achieved by scaling up the programme from two to six local authority areas. These economies of scale are largely achieved by management costs being more highly leveraged once scaled-up, i.e. the need for less management cost once STEER was scaled across six areas. This enables more STEER delivery staff to be overseen by less management cost, meaning that more children can be supported at a lower cost per child.

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[33] This number is based on the maximum capacity for mentors (i.e. 6.6 x 13 young people) and team leaders (i.e. 1.8 x 10 young people). We have rounded this down from 103.8, as a child cannot be partially supported. During this period, the STEER team supported 98 young people, which would cost £1,696.39 per child (which is an additional £82.35 per child).

7 Conclusion

7.1 Key conclusions

Key conclusions
STEER demonstrated **a small negative impact** on children's offending behaviour. Children who received STEER were slightly more likely to report offending behaviour than children who did not receive STEER. There is some uncertainty surrounding the estimate. This result has **a moderate security rating**.
STEER showed a moderate impact on reducing emotional symptoms and a small impact on reducing peer difficulties and on improving pro-social behaviour. It demonstrated a small negative impact on conduct problems. These are secondary outcomes and should be treated with more caution.
STEER may not have been delivered at the intended intensity. Children were recorded as having received, on average, 14 one-to-one mentoring sessions versus the intended 24. Only 50% of families were recorded as having received family support, with an average of three sessions (compared to the expected 14). The reduced dosage may have played some role in preventing the programme's intended impact.
STEER staff and wider stakeholders identified a range of factors that supported effective delivery. The Salford Foundation's strong local presence, trusted relationships and involvement in multi-agency panels were viewed as enabling smooth referral and engagement processes. When expanding into new areas where relationships were still developing, referrals took longer to build. Stakeholders reported high demand for STEER.
Children who received STEER reported stronger relationships with their STEER mentors than children in the control group reported with identified trusted adults. The more mentoring sessions children attended, the stronger these relationships were. Interviews with children also suggested that mentor–mentee relationships were a consistent strength of STEER.

7.2 Evidence to support the STEER theory of change

7.2.1 Overview

The STEER theory of change was refreshed and co-developed by the Salford Foundation, Cordis Bright and the YEF as part of the evaluation co-design and set-up phase of this efficacy study. The theory of change (see Table 5) underpinning STEER provides a clear pathway, including evidence of need; rationale; activities (mentoring, casework and family support); and short-, medium- (emotional regulation, pro-social values, better relationships with peers and trusted adults, etc.) and longer-term outcomes (including reduced offending, gang involvement and serious violence). The theory of change has remained unchanged throughout the efficacy study. The STEER toolkit includes activities aimed at supporting the programme team in delivering its intended outcomes with children on the STEER programme.

7.2.2 Extent of support for the theory of change from the evaluation findings

Findings from this study provide partial support for the STEER theory of change. The results suggest that some of the mechanisms identified in the theory of change operated as intended, particularly those concerning building trusted relationships and supporting children's emotional development, although the quantitative evidence indicated statistically non-significant effects on key outcomes. Key points include:

- **STEER filled an important gap in provision for children at risk of offending in the boroughs in which it operated.** Staff and stakeholders in the IPE reported how STEER played a key role in local responses to reducing offending among children in the local areas in which it worked. They suggested that it filled a gap in service provision that was important in providing children with support to prevent and/or reduce their involvement in offending behaviour.

- **The theory of change is rooted in evidence-based risk and protective factors,** including:

    o Having close relationships with peers, associates and family members who are involved in serious violence, organised crime and gangs (Murray and Farrington, 2008)
    o Having low levels of aspiration (Mahler et al., 2017)
    o Exhibiting risk-taking attitudes and behaviours (such as carrying weapons; Boxford, 2006)
    o Showing poor emotional control (Salinas and Venta, 2021)
    o Having low levels of pro-social values (Boxford, 2006)

    The evaluation findings suggest that STEER addressed these domains to some extent, particularly through mentoring relationships and structured topic-based sessions designed to promote emotional regulation, goal-setting and awareness of consequences.

- **The STEER Toolkit and associated topic areas were viewed positively.** Consultation with children and STEER staff suggested that views of the Toolkit were positive. This included the STEER staff and mentors reporting that the Toolkit was key in supporting the delivery of STEER in a standardised way and as intended in terms of the topic areas covered. Children reported that they found the STEER sessions helpful and valued the relationships they had with their mentors.

- **The quality of the relationships between the mentors and mentees was a consistent strength.** The IPE and impact evaluation findings suggest that the relationships between mentors and mentees were generally positive. The children we spoke to reported that it supported them with regulating their emotions, understanding risk and thinking about the future. Children spoke positively about having someone they could trust and rely on. These insights suggest that the relational mechanisms of the quality of the mentor–mentee relationship, which sits at the heart of the theory of change, were experienced by children. This was backed up by the analysis of the quality of mentor–mentee relationship using the SSRS scale, which showed statistically significantly better quality relationships between mentors and mentees in STEER than the relationships of those in the signposting group with their significant adults. Together, these findings support the theory that strong mentor–mentee relationships are a core active ingredient of STEER.

- **Quantitative evidence found no statistically significant impact of participation in STEER in comparison to those in the signposting group.** The impact evaluation found a statistically non-significant, small increase in the primary outcome of the variety of self-reported offending (Hedges' g = 0.08). In terms of secondary outcomes, the evaluation found a statistically non-significant reduction in emotional symptoms in a favourable direction for STEER (Hedges' g = −0.14). Statistically non-significant effects were observed for peer relationship difficulties (Hedges' g = −0.07) and pro-social behaviour (Hedges' g = 0.02), both in a favourable direction for STEER. There was a non-significant null effect on conduct problems (Hedges' g = 0.02). None of these differences reached statistical significance, and all CIs included zero. Because the trial was powered to detect only moderate effects (≥ 0.19), smaller effects of the magnitude observed here would not be expected to reach statistical significance.

- **Qualitative findings suggested positive changes in outcomes**. Children reported improved relationships with family members and school staff, increased confidence and self-esteem, better emotional control, more awareness of consequences, and re-engagement with education or training. These self-reported changes support the view that the relational and emotional components of

STEER were active and valued by participants, even if they did not produce statistically measurable behavioural change within six months.[34]

Collectively, the findings suggest that while the full causal pathway outlined in STEER's theory of change was only partially realised within the trial period, the relational and emotional mechanisms central to the model were active and valued by children. However, this did not translate into statistically significant reductions in the self-reported variety of offending within the trial period.

7.2.3 Strengths and areas of improvement for the theory of change

Areas with the strongest support

- **STEER provided trusted and valued mentorship.** This was demonstrated by positive SSRS scores and qualitative feedback from participants, suggesting that STEER was effective in building meaningful and supportive mentor–mentee relationships. These findings suggest that the relational mechanisms at the heart of STEER's theory of change were likely active and experienced as intended. Mentoring relationships helped children to feel supported, valued and better able to manage emotions and decision-making. This is consistent with the favourable, though statistically non-significant, direction of effects on emotional symptoms outcomes observed in the impact evaluation.

Areas of the theory of change with weaker or inconclusive support

- **Evidence for the mentoring element of STEER being delivered with good fidelity to the theory of change is mixed**. Qualitative insights from the IPE suggest that STEER was delivered in line with its delivery toolkit. The STEER mentors reported using the toolkit as a reference to ensure consistent delivery. Monitoring data also suggests children received a range of sessions as intended by the programme. However, monitoring data suggest that children received a lower dosage of STEER than intended, i.e. a mean of 14.1 face-to-face sessions compared to the intended 24. This lower dosage likely reduced the overall programme intensity and may help explain the statistically non-significant effects observed in the impact evaluation.

- **The family support element of the STEER theory of change had limited uptake from parents or carers.** As such, its potential contribution to outcomes cannot be assessed in this study. This may be a key part of the programme that can work to support children in reducing their involvement in offending. However, despite adjustments made post internal pilot, it remained a weaker component in both reach and intensity. This component remains a promising but underutilised part of the programme, and future delivery should focus on clarifying its purpose and strengthening engagement. As discussed in the IPE findings section, Salford Foundation staff suggested this was because of a number of reasons, including (1) challenges in working with several professionals, i.e. from STEER and from other agencies which may be supporting them, and/or (2) participants perceiving family support as parent support and declining formal help.

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[34] Please note, we did not conduct interviews with young people in the control group, so we do not know whether they would report similarly about improvements in these areas.

- **Outcomes related to educational engagement and employment readiness were not captured in evaluation measures.** These elements of STEER's theory of change remain underexplored – although there was some emerging evidence from the qualitative interviews with children that STEER may contribute to improving these outcomes.

- **Behavioural and well-being changes were statistically non-significant.** The assumption that improvements in emotional symptoms and pro-social values would translate into measurable reductions in offending was not empirically supported within the six-month follow-up window of this evaluation. This could reflect a range of reasons, including the trial having limited statistical power to detect small effects, STEER not being delivered in line with its theory of change, reduced programme intensity and, potentially, the short evaluation timeframe. The findings suggest that the proximal mechanisms in STEER's theory of change (e.g., trusted relationships and emotional regulation) were activated as intended, but the distal outcomes (reduced offending) were not detected within the trial period. Achieving measurable behavioural change may require higher dosage, stronger family engagement and longer-term follow-up to capture delayed or cumulative effects.

7.2.4   Considerations for further research

- **Long-term outcomes.** The impact evaluation's six-month follow-up may have been insufficient to detect delayed or cumulative effects. For instance, some STEER staff members mentioned that for some children, the impact of involvement in STEER may not become apparent for some time after involvement in STEER. Evaluating these potential 'sleeper effects' (Tennent et al., 2007) would require longer-term follow-up (e.g. at 12 and 24 months). This would help determine whether the statistically non-significant favourable effects observed on emotional symptoms, peer difficulties and pro-social values at six months may develop into measurable behavioural change over time.

- **Statistical power and measurement.** Future studies should be designed and powered to detect small effects, which are typical of mentoring interventions. The present trial was powered to detect only moderate effects (MDES ≥ 0.19); consequently, effects observed (Hedges' $g \approx -0.14$ to 0.08) would not be expected to reach statistical significance. Future evaluations should, therefore, consider larger samples, improved measures of offending (e.g. SRDS subscales or police data) and longitudinal mixed-methods approaches to triangulate quantitative and qualitative findings.

- **Differential impacts.** Exploratory subgroup analysis found no statistically significant differences by ethnicity. However, the study was not powered to detect subgroup effects. Further research with larger, equity-powered samples is warranted to assess whether STEER operates differently for children of different genders, ethnicities or baseline risk levels and across varied local service contexts.

- **Family involvement.** Given its importance to the theory of change, more targeted research, for example, researching the existing literature and/or conducting primary research, on the barriers and facilitators to engaging parents or carers, especially in deprived, structurally disadvantaged contexts and contexts where families are involved in offending behaviour, is warranted.

- **Comparative and implementation research.** Comparative studies could situate STEER within the wider landscape of youth violence-prevention and mentoring interventions in the UK, building on insights from the YEF Toolkit. Future work could also explore how fidelity, dosage and mentor

characteristics (e.g. diversity, cultural competence and supervision) influence effectiveness and sustainability across contexts.

7.2.5 Potential areas for theory of change improvement

Based on the findings of this study, there is no evidence that the core components or mechanisms of the theory of change are invalid. However, the following modifications may be considered:

- **Timescales and intensity.** The assumption that six months is sufficient for children to progress from improved emotional and relational outcomes to measurable reductions in offending may be optimistic, particularly for a cohort with complex needs and structural disadvantage. The statistically non-significant favourable effects on emotional symptoms, peer difficulties and pro-social values may indicate early-stage progress that requires more sustained support to consolidate. The theory of change could therefore be refined to reflect (1) a longer delivery period for STEER to allow proximal changes (e.g., emotional regulation and trust) to translate into behavioural outcomes and/or (2) greater intensity of mentoring, such as increasing the frequency or duration of sessions. While increased dosage poses operational challenges, it is consistent with international evidence that higher exposure to structured, relationship-based mentoring is associated with stronger outcomes over time.

- **Family support.** The family support component of the theory of change was not implemented as intended, with limited uptake from parents and carers. This restricted its potential contribution to outcomes. The theory of change should be refined to reflect the realities of delivery. This could be either by (a) moderating the expected role of family support or (b) strengthening the delivery model to ensure it plays its intended part. Strengthening may require a clearer communication of purpose, more flexible engagement methods and closer integration with existing family or multi-agency support services.

- **Intervention pathways and assumptions.** The revised theory of change should explicitly account for:
    - Change likely being stepwise and cumulative, moving from proximal (emotional regulation and pro-social values) to distal (behavioural and offending) outcomes over time
    - Fidelity and dosage being critical preconditions for impact that should be monitored explicitly.
    - External contextual factors, such as local service provision, overlapping interventions and socioeconomic conditions, that can moderate both implementation and outcomes

7.3 Interpretation of findings

7.3.1 Answering the key research questions

The aim of the efficacy study with the internal pilot was to address the following key research question:

"Does a co-designed mentoring, coaching, family support and case management programme delivered to children with known family members or peers involved in offending behaviour

The efficacy study included a two-armed RCT, which was delivered in line with the efficacy study protocol and SAP.

The findings indicated no statistically significant difference between the STEER and signposting groups on the primary outcome of self-reported offending variety. Participation in STEER was associated with a statistically non-significant small increase in the variety of self-reported offending (Hedges' g = 0.08). The CI included zero, indicating uncertainty around the true direction of the effect.

Across the secondary outcomes, there were no statistically significant differences between groups. STEER was associated with statistically non-significant favourable effects on emotional symptoms (Hedges' g = −0.14), pro-social behaviour (Hedges' g = 0.02) and peer relationship difficulties (Hedges' g = −0.07). Findings showed no measurable effect on conduct problems (Hedges' g = 0.02).

For all outcomes, the CIs included zero, meaning that the true effects could be positive, negative or zero. The trial was powered to detect moderate effects (≥0.19), and, therefore, smaller effects of the observed magnitude would not be expected to reach statistical significance within this sample size.

In addition to the primary research question, the study addressed a number of questions presented in Table 35.

Table 35. Key research questions and summary answers

Research question	Summary
Delivery. Can the STEER programme work under ideal circumstances?	Findings suggest mixed evidence that STEER was delivered with fidelity across six Greater Manchester boroughs. This may have been affected by the operational pressures of a large-scale randomised controlled trial, which included the Salford Foundation effectively scaling up and spreading STEER from two to six boroughs during the efficacy study. Core elements of the STEER model, including weekly one-to-one face-to-face mentoring, wraparound casework, and the use of the Toolkit, were implemented consistently, although monitoring data suggests a lower dosage than anticipated, and mentor–mentee relationships were generally strong and valued by participants. Monitoring data and consultation with STEER staff suggested that take-up of the family support offer was lower than anticipated, suggesting that while the core mentoring model can operate effectively, the family support component may require further adaptation to maximise engagement.
Impact. What is the impact of STEER? For whom does STEER work, and under what conditions?	STEER was associated with a statistically non-significant small increase in the variety of self-reported offending (Hedges' g = 0.08), and statistically non-significant favourable effects on secondary outcomes, including emotional symptoms (Hedges' g = −0.14), peer-relationship difficulties (Hedges' g = −0.07) and pro-social values (Hedges' g = 0.02). No statistically significant

Research question	Summary
	subgroup differences were found by ethnicity. For all outcomes, confidence intervals (CIs) included zero, indicating uncertainty around the true direction of effects. The secondary outcome findings are partially consistent with relational and emotional development as precursors to behavioural change within STEER's theory of change; however, estimates were not statistically significant.
	Qualitative findings and Social Support and Rejection Scale data suggest that mentoring relationships supported improvements in trust, emotional regulation and engagement, particularly where mentoring was consistent and tailored. The lack of statistically significant effects likely reflects both reduced fidelity and dosage and the trial's limited power to detect small effects. Furthermore, 10 or more mentoring sessions (out of an intended 24 sessions) were not associated with a statistically significant reduction in offending variety. Further research is warranted to test potential longer-term (sleeper) effects and to explore differential impacts across subgroups and local contexts.
Unintended consequences. Does STEER have any unintentional consequences? If so, what are these? Do different groups of children experience these differently?	There was no evidence of major unintended consequences of the STEER programme reported by the children, staff members or wider stakeholders we spoke to. Children generally described their involvement in STEER positively, highlighting the voluntary nature of the programme and the strength of their relationships with mentors. A small number of children were disappointed and sad when the programme ended, though this was not widespread. There was no evidence in this study to suggest that different groups of children (e.g. by gender, ethnicity or special educational needs and disabilities status) experienced unintended consequences differently.
Iatrogenic effects. Are there any serious negative effects attributed to STEER on any intended or unintended outcomes?	The evaluation found no evidence of serious negative or iatrogenic effects on any measured outcomes attributable to STEER. No safeguarding concerns or harms were reported. On measured outcomes, no statistically significant harmful effects were detected. The primary outcome showed a small, non-significant increase in the variety of self-reported offending (Hedges' $g = 0.08$), with the CI crossing zero, so we cannot conclude that STEER increased offending. For secondary outcomes, effects on emotional symptoms ($g = -0.14$), pro-social behaviour ($g = 0.02$) and peer difficulties ($g = -0.07$) were favourable in direction for STEER but not statistically significant. There was no measurable effect for conduct problems ($g = 0.02$). Taken together, these findings indicate no statistically significant adverse effects.
Mechanisms. How does STEER work to reduce children's involvement in serious youth violence? Which factors contribute	The evidence suggests that STEER's primary mechanism operates through the development of consistent, trusting relationships between mentors and children. These relationships fostered emotional regulation, reflection on risk and positive goal-setting. The trauma-informed, strengths-based approach helped children feel respected and supported. However, measurable

Research question	Summary
most to the observed outcomes?	behavioural change was not evident within six months, indicating that more time, higher dosage (including more children receiving the intended 24 sessions) and fuller engagement with families may be required for these mechanisms to translate into reductions in offending.

7.3.2   Policy context and contribution to knowledge

STEER was implemented within a challenging policy context marked by rising serious youth violence in Greater Manchester and growing recognition of the limitations of statutory responses. It was developed to fill a clear gap in provision for children exposed to family or peer offending. Its asset-based, trauma-informed and voluntary model of participation aligns closely with current youth justice and early intervention policies, including the principles of the Greater Manchester Serious Violence Action Plan (2020), which explicitly recognised the potential of STEER.

The findings of this evaluation contribute new UK evidence to a limited but growing literature on mentoring as a violence prevention approach. International meta-analyses and systematic reviews show that mentoring can have low-to-moderate positive impacts on reducing crime and antisocial behaviour, with effectiveness influenced by programme design, mentor quality and intensity of engagement. Within this evidence base, UK randomised trials remain scarce, and results have been mixed. This study, therefore, represents an important and rigorous UK test of a trauma-informed mentoring programme delivered at scale to a high-risk cohort.

Consistent with the international evidence, the STEER trial found no statistically significant effects on the primary or secondary outcomes. The analysis identified a statistically non-significant increase in the variety of self-reported offending (Hedges' g = 0.08); non-significant favourable effects for STEER on emotional symptoms (Hedges' g = −0.14), pro-social behaviour (Hedges' g = 0.02) and peer difficulties (Hedges' g = −0.07); and non-significant null effects on conduct problems (Hedges' g = 0.02). For all outcomes, the CI included zero, indicating uncertainty about the true direction of the effects.

However, the pattern and direction of findings were broadly consistent with STEER's theory of change, suggesting that the proximal relational and emotional mechanisms, such as trust, emotional regulation and engagement, were likely activated. Achieving measurable behavioural change may require greater intensity, longer duration or future trials powered to detect small-to-moderate effects. This aligns with the wider international evidence that mentoring impacts tend to be contingent on sustained exposure, fidelity and dosage, particularly for children facing multiple and structural vulnerabilities.

The STEER evaluation makes several distinct contributions to the field. These include:

- Demonstrating that delivery of a complex, multi-component intervention to a high-risk cohort is feasible at scale within a rigorous RCT design
- Providing one of the most comprehensive UK-based tests of a trauma-informed mentoring intervention, which included robust attention to EDI in its delivery approach
- Offering insights into how relational mechanisms function within mentoring, i.e. highlighting the role of trust and emotional regulation as early indicators of progress
- Highlighting the importance of programme delivery in line with model fidelity

- Raising important questions about the timescales and intensity needed to achieve and observe meaningful impact among children with complex vulnerabilities and entrenched contextual risks
- Underscoring the need to consider the quality and availability of existing BAU services and the extent to which access to other effective support may influence measured differences between treatment and control groups

Overall, STEER strengthens the UK evidence base on youth mentoring by illustrating both its potential and its practical limits within a real-world system context. It demonstrates that trauma-informed, voluntary mentoring can engage children with complex needs, but achieving measurable reductions in offending may depend on sustained engagement, stronger family involvement, longer delivery periods and longer-term investment, as well as future trials powered to detect small-to-moderate effects.

7.3.3 Considerations for developing STEER and similar mentoring programmes in the future

Wider stakeholders reported that mentoring programmes like STEER are a key part of local support systems for children at risk of or involved in offending behaviours. There is a strong need and demand for a programme like STEER across Greater Manchester, with multiple local stakeholders viewing its voluntary, trauma-informed approach as a valuable alternative to statutory responses. Since the efficacy study with the internal pilot began, other programmes offering similar support, such as AFRUCA, Remedi and Turnaround, have expanded provision in the region, further demonstrating the perceived need for mentoring and wraparound services tailored to children on the cusp of serious offending. Given this context, the findings of this efficacy study suggest the following considerations for STEER and similar mentoring programmes:

- **Focus on the mentoring relationship being consistent and trusted over time.** Findings suggest that trusted, consistent mentoring relationships were a defining strength of STEER. Children frequently described their mentors as reliable, respectful and non-judgmental, and this was reflected in higher SSRS scores for the STEER group. Qualitative data suggests that these relationships supported improvements in confidence, goal setting and emotional regulation: key mechanisms in the programme's theory of change. Future mentoring programmes should prioritise conditions that sustain high-quality mentoring relationships over time. These may include manageable caseloads, low staff turnover, structured training and supervision, and an emphasis on continuity of contact, especially for children with complex or unstable circumstances.

- **Increase engagement, dosage and duration.** The quantitative findings showed a statistically non-significant small increase in the variety of self-reported offending (Hedges' g = 0.08) and statistically non-significant favourable effects on emotional symptoms (Hedges' g = −0.14), pro-social behaviour (Hedges' g = 0.02) and peer difficulties (Hedges' g = −0.07), with CIs including zero. These patterns are consistent with partial implementation fidelity and lower-than-intended dosage: Only a small proportion of children received the full 24 planned one-to-one mentoring sessions. To strengthen the potential for measurable impact, future programmes could a) increase the proportion of participants receiving the intended session dose, ensuring that delivery is closer to the planned model, b) extend delivery beyond six months or explore offering more frequent mentoring contact (e.g. 2–3 hours per week) to support continuity and relationship depth and c) embed flexible engagement strategies, for example, holding sessions in community settings or maintaining contact through digital platforms to sustain participation among children facing instability or multiple service involvement. Such adjustments might help ensure that proximal relational and emotional mechanisms (e.g. trust,

emotional regulation and engagement) have sufficient time and intensity to be reflected in detectable behavioural outcomes in future evaluations.

- **Take a whole-family approach.** The STEER theory of change emphasised linking individual mentoring support to family engagement, but uptake of the family support offer was limited. This may have constrained its potential contribution to outcomes. Strengthening this component could enhance programme effectiveness, particularly where family environments contribute to risk factors for offending. Future iterations might benefit from clarifying the role and purpose of family support, adopting flexible engagement approaches (e.g., home visits or joint mentor–family sessions) and coordinating with existing multi-agency or family-based services. Adopting a whole-family approach may help sustain change beyond the mentoring relationship.

- **Ensure flexibility in delivery to meet children where they are.** Children responded positively to the flexible, informal and voluntary nature of STEER. The ability to meet in locations and at times that suited them was often cited as a reason for sustained engagement. Maintaining flexibility while ensuring sufficient structure to support progression appears to be a key ingredient for working effectively with this cohort. This is something that mentoring programmes should consider in the future.

- **Integrate mentoring programmes into the wider system.** Wider stakeholders reported that STEER was well integrated into local systems and that it was a key part of their local system's response to serious youth violence. They valued the Salford Foundation and STEER. This was critical to STEER being able to scale and spread so rapidly in the challenging context of an RCT. Linked to this, mentoring programmes are more likely to be successful in working with children with complex needs and those who are vulnerable when they are well integrated into the existing system, such as by having good links with schools, youth justice services and police. STEER achieved this by attending local multi-agency panels (e.g. PIED and Engage) and by involving statutory partners in a strategic steering group. Mentoring programmes may be more effective when they are well integrated into local systems. Lasting behaviour change requires coordinated efforts across systems, including, for example, family, education, justice, housing and mental health, to create the conditions in which children can make and sustain different choices. This includes providing wider support to families, which may make the child's home environment more conducive to positive change.

- **Ensure equity and structural interpretation.** Subgroup analysis provided no clear evidence that STEER's impact varied by ethnic background, likely because the analysis was exploratory and underpowered. Furthermore, subgroup analyses cannot capture the broader structural factors that may underpin differences, such as disparities in access to services, variation in school environments, the availability of trusted adults and differences in local provision, which are likely to shape engagement and outcomes in meaningful ways. Future research should (a) consider research with larger and more diverse samples that are sufficiently powered for an equity analysis and (b) prioritise exploring these structural determinants to better understand and address inequities in implementation and impact.

7.4   Limitations and lessons learned

7.4.1   Limitations of the evaluation

The STEER efficacy study with internal pilot included a theory-led, two-armed, parallel RCT combined with IPE. While the study was completed to a high standard, several limitations should be considered when interpreting the findings:

- **Risk of bias – attrition and missing data.** The study achieved a strong recruitment sample that was broadly in line with power calculations, and baseline characteristics were well balanced across arms. However, there was a higher-than-anticipated rate of missing outcomes data at follow-up, which introduced some risk of attrition bias. Analyses indicated that the data was likely MAR. To address this, sensitivity analyses were conducted using multiple imputation methods. These results were consistent with the CCA and did not materially alter the findings. On this basis, we believe the risk of bias is low and has been effectively mitigated.

- **Limited statistical power to detect small-to-moderate effects and to conduct subgroup analyses.** The sample achieved the target size specified in the SAP, and it was powered in line with YEF guidance at the time, which recommended an MDES of 0.20 to identify moderate effects. However, the small, statistically non-significant effects observed on self-reported offending (Hedges' g = 0.08) and the statistically non-significant favourable effects on emotional symptoms (Hedges' g = −0.14), pro-social values (Hedges' g = 0.02) and peer difficulties (Hedges' g = −0.07) were below this MDES and were, therefore, unlikely to reach statistical significance even if true population effects existed. This means that the absence of statistically significant findings should not be interpreted as evidence of ineffectiveness; rather, the trial was not designed to detect smaller but potentially meaningful effects. Future studies might consider larger samples to enable the detection of low-to-moderate, policy-relevant effects and to strengthen confidence in null findings. Similarly, exploratory subgroup analyses (e.g. by ethnicity) were not powered to detect differences, limiting confidence in differential impacts. Future evaluations seeking to explore variations across demographic groups would require larger sample sizes and additional resources to ensure equity-powered designs.

- **Potential for impact dilution.** As part of the signposting (control) group, children were informed about other local services consistent with a BAU approach. Access to these alternative services might have provided comparable forms of mentoring, youth work or family support. The type and extent of services accessed by the signposting group were not systematically recorded or quantified. The signposting group's access to these services could have reduced the contrast between groups, potentially underestimating STEER's true impact. Such limitations are common in community-based RCTs, where ethical and practical considerations require offering participants access to other forms of support.

- **Length of follow-up.** The six-month post-randomisation follow-up aligned with the duration of the STEER intervention but may have been too short to capture delayed or cumulative effects. Many relational and developmental changes, such as improved trust, emotional regulation and goal-setting, may take longer to translate into measurable behavioural outcomes. Longer-term follow-up (e.g. 12–24 months) would help determine whether the statistically non-significant favourable effects observed on emotional symptoms, peer difficulties and pro-social values represent early-stage progress that consolidates over time. However, the absence of statistically significant effects during

the active delivery phase still provides useful insight into the short-term immediacy of measurable change. If larger behavioural shifts occur, they may require sustained engagement beyond a six-month intervention window. While longer-term evaluations involve greater cost and potential attrition, they would provide valuable evidence, given both the high social costs of crime and the recurring pattern of small or null short-term impacts observed across mentoring evaluations.

Overall, these limitations do not undermine the validity of the findings but contextualise them. The trial offers a robust and credible estimate of STEER's impact after six months while highlighting the need for longer-term, better-powered studies to detect smaller but meaningful effects, explore subgroup variations and understand how implementation quality shapes outcomes.

7.4.2 Lessons for future evaluations

This evaluation contributes to the knowledge base that RCTs of mentoring programmes in the UK are achievable and desirable to develop the evidence base about what works, to move towards a culture of more robust evidence and to support providers in improving practice. The following presents some key lessons for future evaluations based on the experience of delivering the STEER RCT.

- **An innovative, committed and flexible provider willing to work closely with the funder and evaluator.** The Salford Foundation is an innovative, committed, supportive and flexible provider. It is ahead of the curve, being one of the first UK mentoring providers to subject its programme to the rigour of an RCT. This type of evaluation places significant additional demands on providers, including adhering to random allocation, maintaining consistency in delivery while accommodating research protocols, and operating within strict timelines and data collection requirements. The organisation's willingness to engage fully with these challenges was evident throughout, reflected in its flexibility, adaptability and collaborative approach to working with the YEF and Cordis Bright. The Salford Foundation is an innovator in this area and should be recognised as such.

- **A provider willing to build support for the RCT.** The Salford Foundation played a proactive role in building and maintaining stakeholder buy-in across six boroughs, tailoring the programme to complement local services and referral pathways. This included embedding STEER within existing multi-agency panels (e.g. PIED and Engage), aligning the referral process with local priorities and establishing a strategic steering group to oversee delivery and encourage inter-agency ownership. This effort and achievement from the Salford Foundation was critical to the success of delivering this efficacy study.

- **A collaborative approach.** We took a collaborative approach to working with the Salford Foundation and the YEF on the evaluation. This included several aspects which we think supported the successful delivery of the evaluation:

  - **Co-design, theory of change and STEER Toolkit.** We worked closely with the Salford Foundation during co-design and evaluation setup, including on refreshing and rooting the theory of change in existing evidence and providing feedback on the STEER Toolkit. This resulted in a number of refinements to the Toolkit to ensure clarity, consistency and alignment with the programme's theory of change.

  - **Training and guidance on evaluation processes.** We provided training and ongoing support to delivery staff on key evaluation processes, including the administration of baseline (T1)

and follow-up (T2) questionnaires and the implementation of the randomisation protocol. Our support included the delivery of a co-designed (with the STEER team) evaluation handbook, which was provided as a reference for all key aspects of the evaluation. This helped improve confidence among staff and reduced the risk of procedural errors. We also provided support to the STEER team concerning the importance of accurately recording monitoring data in the Salford Foundation client relationship management system following the internal pilot report.

- o **Regular communication to support recruitment and data collection.** We provided weekly email updates summarising referral numbers, participant progress through randomisation and completion rates for T1 and T2 questionnaires. These updates provided clear visibility on trial progress and enabled the Salford Foundation to prioritise actions to reach recruitment targets.

- **Real-time monitoring data.** The approach to recording and reporting monitoring data improved during the study. However, future evaluations could benefit from developing a monitoring system which provides more timely updates concerning programme delivery and ensures consistency in how mentors record programme activity. This would require additional resources but would be useful for both the evaluation team and the provider to monitor what is being delivered to whom in real time. This would support supervision and help to provide greater confidence that the programme is being delivered with fidelity in real time.

- **Scale-up during RCT delivery.** The Salford Foundation's achievement in scaling up STEER from two Greater Manchester boroughs to six during the trial should not be underestimated. This expansion was necessary to achieve a sufficiently powered sample within YEF funding timelines and reflects the organisation's strong reputation and delivery capacity. However, scaling up while operating under RCT conditions, for example, strict adherence to research protocols, randomisation and standardised delivery, may not represent ideal implementation conditions. Evaluators, funders and providers should consider how the pressures of scaling and evaluation may interact to influence delivery and outcomes**.**

- **EDI and race equity embedded in programme delivery.** The Salford Foundation embedded a strong focus on EDI within its delivery strategy. This included recruiting and training staff with diverse lived experiences, adapting engagement approaches to better meet the needs of different groups, working with other organisations to share learning and continuously reflecting on referral patterns and cohort diversity.

- **Consistent funding.** There is a challenge around uncertain funding for providers like the Salford Foundation. During this evaluation, there were two periods of funding uncertainty – first, during the transition period between the internal pilot and the full efficacy study, which resulted in a pause with referrals, and second, towards the end of the efficacy study, when referrals were put on pause and staff were made redundant. Both these periods created uncertainty and likely negatively impacted those delivering the programme, as funding uncertainty leads to role uncertainty. For example, stakeholders reported uncertainty about what would happen to referrals beyond the study, but they were hopeful that this would be resolved. This may have had implications for how STEER was delivered during these periods and may have influenced final sample sizes. Sustained,

multi-year funding helps maintain engagement, protect staffing capacity and support fidelity. These are all factors that influence measurable impact.

- **Investment of provider resources.** The Salford Foundation provided resource investment beyond the initial scope of the trial. Following a short pause between the internal pilot and the efficacy phase, the Salford Foundation worked to maintain delivery momentum and re-establish partner engagement. It also contributed to delivery costs for an additional two months at the end of the trial to ensure recruitment targets were met and a sufficiently powered evaluation could be conducted. This level of engagement, particularly in the context of a trauma-informed programme working with children affected by serious youth violence, underscores the central role of delivery partner leadership in ensuring the feasibility and integrity of complex evaluations.

- **Evidence triangulation and a mixed-methods approaches.** To generate a robust understanding of mentoring programmes, such as STEER, we recommend the YEF approach of combining an RCT with a comprehensive IPE. The RCT provides essential insights into impact and causality, providing useful insights into the overall effect on offending. The IPE offers valuable context on how the programme was delivered, experienced and received by children, staff and wider stakeholders. Using both quantitative and qualitative approaches ensures that findings are rigorous and grounded in real-world implementation, helping funders, commissioners and practitioners make better-informed decisions about design, scalability and sustainability.

- **Design for statistical power and duration.** Future evaluations of mentoring programmes should plan for larger sample sizes or cluster designs capable of detecting small-to-moderate effects, which are typical of complex social interventions. They should also consider longer follow-up periods (e.g. 12–24 months) to capture delayed behavioural changes. Building these design elements into future studies will ensure more definitive evidence about the size and sustainability of mentoring impacts.

Generally, we found that a collaborative, embedded approach proved valuable in supporting the delivery of the RCT. Our experience also highlighted the importance of capacity building, flexible communication and shared ownership of the evaluation processes when working with delivery partners.

Generalisability of findings

The findings of this efficacy study are likely to be most relevant to other urban areas in the UK with similar levels of youth violence, deprivation and service infrastructure. The STEER programme was delivered across six boroughs in Greater Manchester, and children involved in the study were identified by professionals, including police, youth justice services and education, as being at high risk of serious violence, gang involvement or exploitation. This suggests that the findings may be relevant to similar high-risk populations in urban areas with comparable characteristics.

However, there are some important limitations to how far the findings can be applied elsewhere:

- The programme was delivered by an experienced VCSE organisation (the Salford Foundation) that has strong local relationships and credibility. This helped with engagement and delivery in ways that may not easily be replicated in other areas.

- While the study included children from a wide range of ethnic backgrounds, it was not sufficiently powered to detect differences in how the programme might work for different groups. This means

we cannot draw strong conclusions about its effectiveness for demographic groups, e.g. different ethnic minority subgroups.

- The programme was tested over a period of six months. It is possible that benefits may take longer to emerge, especially for children facing multiple and complex challenges, such as those who participated in the STEER programme. Given that observed effects on emotional and peer-related outcomes were statistically non-significant, benefits may take longer to emerge or require higher dosages to become measurable.

- Overall, care should be taken when applying the findings of this study of STEER to different locations, populations or delivery organisations. More research would be needed to understand how the programme works in other contexts and whether it produces different results.

7.5   Future research and publications

The STEER efficacy study has raised several important questions that can inform future evaluations of STEER itself and similar mentoring programmes. While impact evaluation findings were statistically non-significant and small, they provide valuable insights for the design of subsequent trials and for strengthening understanding of how mentoring interventions may influence offending and well-being outcomes over time. The study raises the following questions:

- **Does STEER have an impact on other measures of offending behaviour?** The efficacy study was delivered in line with our protocol and SAP. However, future studies could consider different measures of offending behaviour that could be explored, including a) creating subscales from the SRDS, as it covers delinquent acts and more serious offences, i.e. looking at developing subscales linked to seriousness, b) using different self-report scales of offending, and c) using police data.

- **What is the long-term impact of STEER on offending and other behavioural outcomes?** Extending the follow-up period beyond six months would help provide insights into whether participating in STEER increases the likelihood of not engaging in offending six months post-programme end (rather than in the six months during which children were participating in STEER).

- **What are the differential impacts of STEER across subgroups?** Larger, equity-powered RCTs are needed to assess effectiveness by ethnicity, age, gender and baseline risk level. These would likely require longer timescales and greater resourcing.

- **How do STEER and similar mentoring programmes compare to other violence prevention interventions?** Comparative effectiveness studies could situate STEER within the broader landscape of youth justice and prevention in the UK. The YEF Toolkit provides a useful starting point for exploring these issues.

Based on the findings of the STEER efficacy study, there are a number of further avenues for potential investigation concerning EDI:

- Exploration of cultural relevance and the perceived accessibility of different programme components for those from minoritised communities. For example, this could explore how accessible and culturally relevant the family support elements of STEER and similar programmes are.

- Investigation of the role of practitioner diversity and cultural competence in facilitating trust and impact

- Greater use of participatory approaches to involve children from minoritised communities in co-designing and interpreting research

These areas of enquiry are essential to ensure mentoring programmes like STEER are not only effective but also equitable and responsive to the structural realities faced by racially minoritised children.

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Appendix A: Changes since the previous evaluation

Appendix Table 1. Changes since the previous evaluation

	Feature	Pilot to efficacy stage
Intervention	Intervention content	No changes.
	Delivery model	In addition to delivery in Wigan and Trafford, the intervention rapidly scaled up delivery to four new boroughs: Salford, Tameside, Manchester and Bolton.
	Intervention duration	Time 3 visit only took place for those who consented to be involved in the project and evaluation prior to September 2023
Evaluation	Eligibility criteria	No changes.
	Level of randomisation	No changes.
	Outcomes and baseline	Time 3 outcome measures were no longer to be administered.
	Signposting group	No changes.

Appendix B: Effect size estimation

Appendix Table 2. Effect size estimation

Outcome	Unadjusted differences in means	Adjusted differences in means	STEER group		Signposting group		Pooled variance
			n (missing)	Variance of outcome	n (missing)	Variance of outcome	
SRDS variety score	0.26	0.28	257 (80)	8.93	257(100)	7.73	8.35
SDQ pro-social scale	0.00	0.05	261 (76)	4.37	261 (91)	4.37	4.37
SDQ emotional problems	-0.32	-0.29	259 (78)	5.76	257 (95)	6.81	6.30
SDQ conduct problems	-0.03	0.04	259 (78)	3.92	258 (94)	4.63	4.27
SDQ peer problems	-0.27	-0.15	261 (76)	3.58	261 (91)	4.30	3.94

Appendix C: Baseline histograms

Below we set out the histograms for baseline scores for the SRDS variety score and four SDQ subscales, for all children across both trial arms with a valid score at T1 (n= 681 to 684). The histograms show the distribution of baseline scores for the SRDS variety score and the four SDQ subscales for all participants with valid data at Time 1 (T1). Across all five measures, the distributions appear approximately normal with slight positive skew for some outcomes. The SRDS variety score (

Appendix Figure **1**) shows a moderate spread with a slight positive skew, indicating a clustering of children reporting involvement in fewer types of offending behaviours. The SDQ prosocial behaviour subscale (Appendix Figure 2) is left-skewed, as expected, with most children scoring toward the higher (more prosocial) end. Emotional problems, conduct problems, and peer problems subscales (Appendix Figure 3,

Appendix Figure **4** and Appendix Figure 5) are approximately symmetric, with a mild right skew for emotional and peer problems, reflecting the presence of a minority of children reporting higher levels of difficulties.

These distributions suggest that the measures capture a broad range of variation in the cohort at baseline and are suitable for use in regression analyses.

Appendix Figure 1. Histogram for the SRDS variety score at T1 (n=684, mean = 5.10, SD = 3.46)
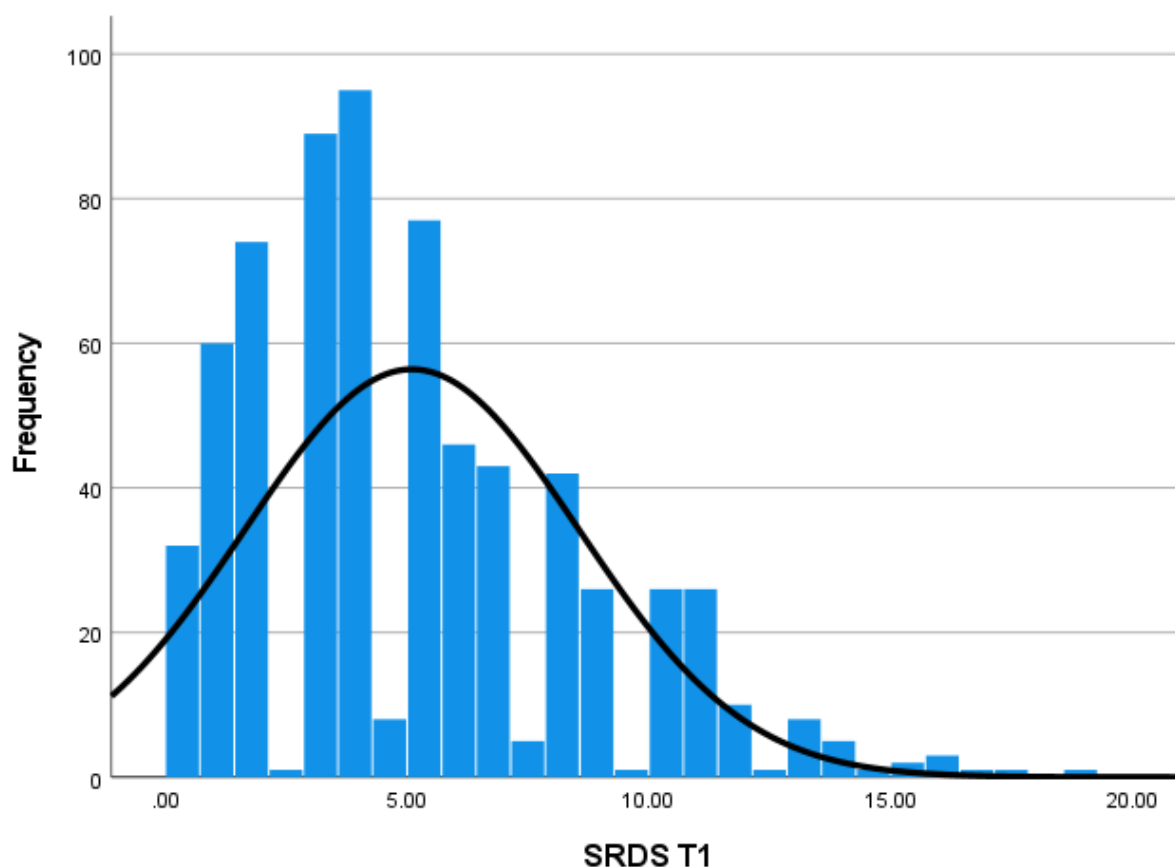
Appendix Figure 2. Histogram for the SDQ prosocial behaviours score at T1 (n=687, mean = 6.15, SD = 2.13)
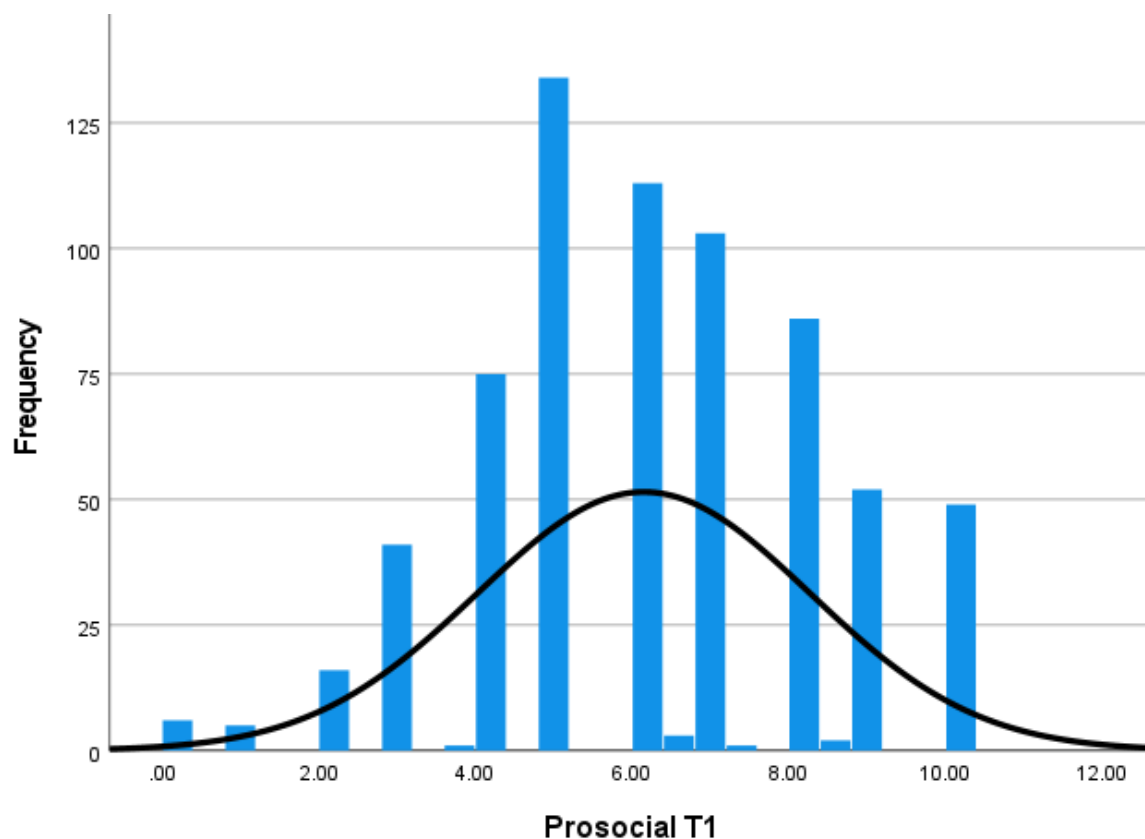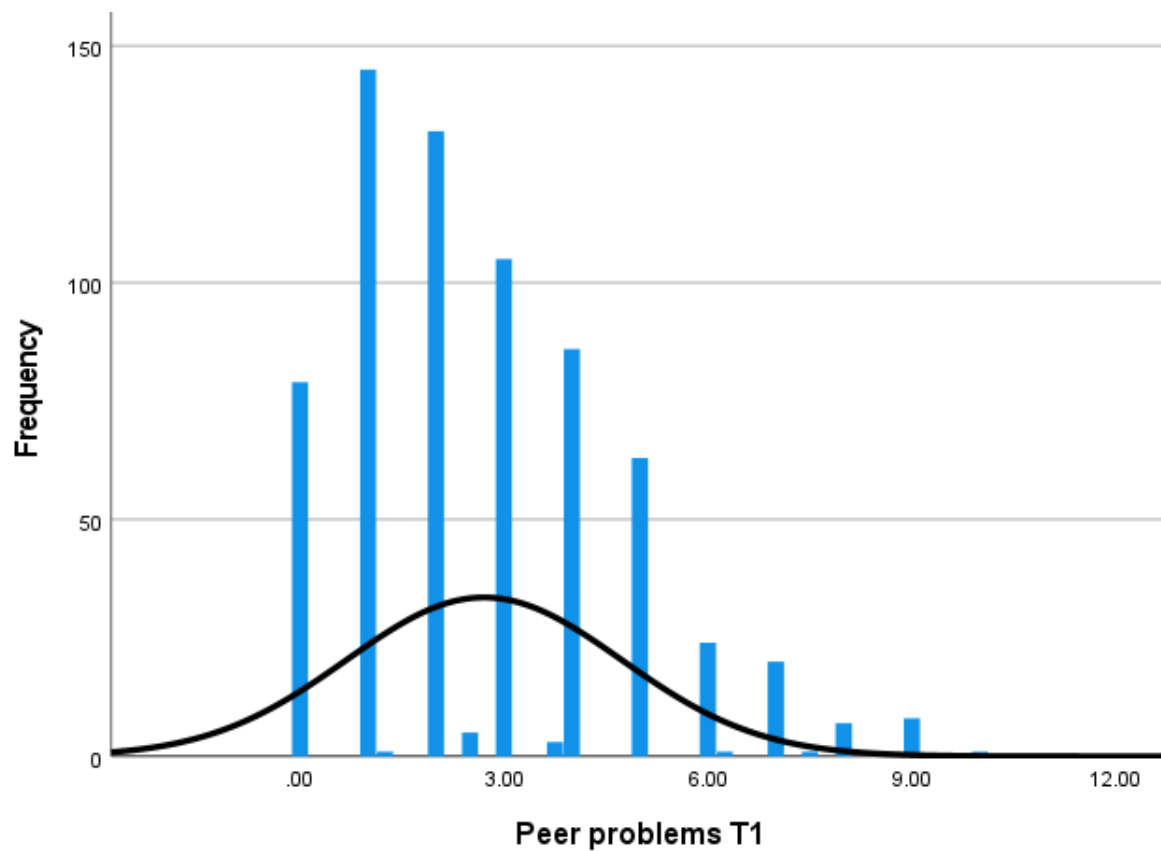

Appendix Figure 3. Histogram for the SDQ emotional problems scores at T1 (n=681, mean = 3.85, SD = 2.56)
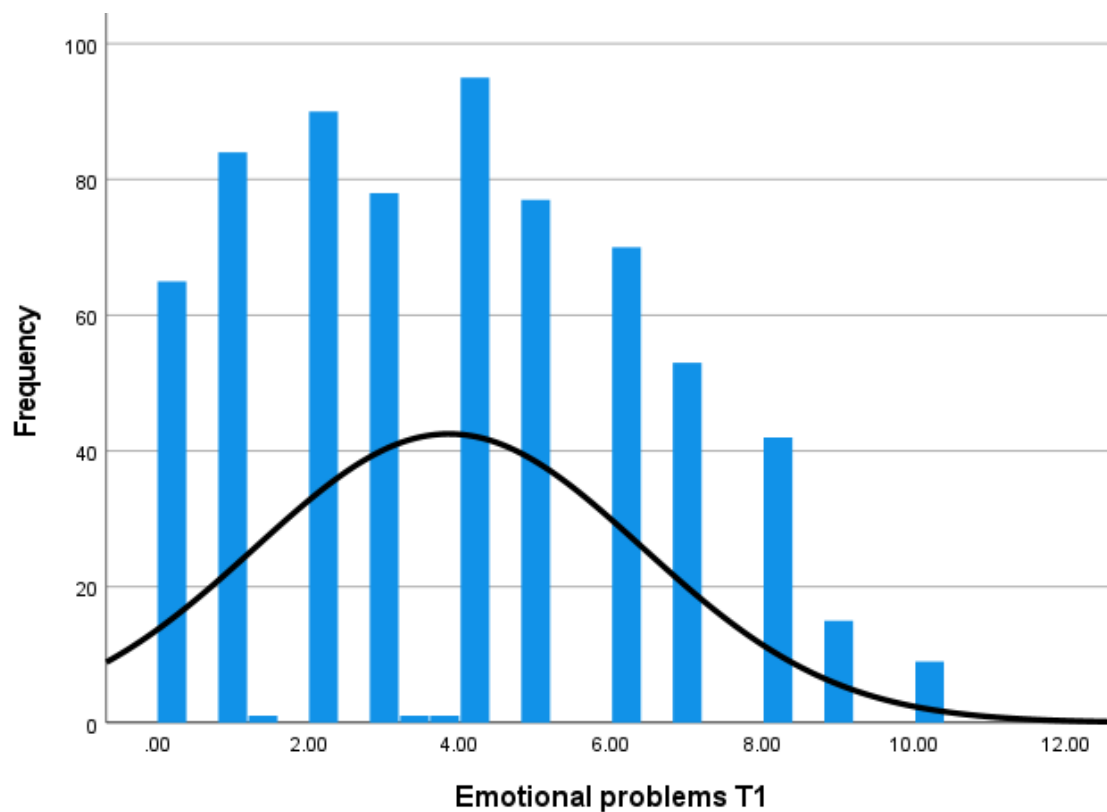
Appendix Figure 4. Histogram for the SDQ conduct problems scores at T1 (n=681, mean = 5.13, SD = 2.00)

Conduct problems T1
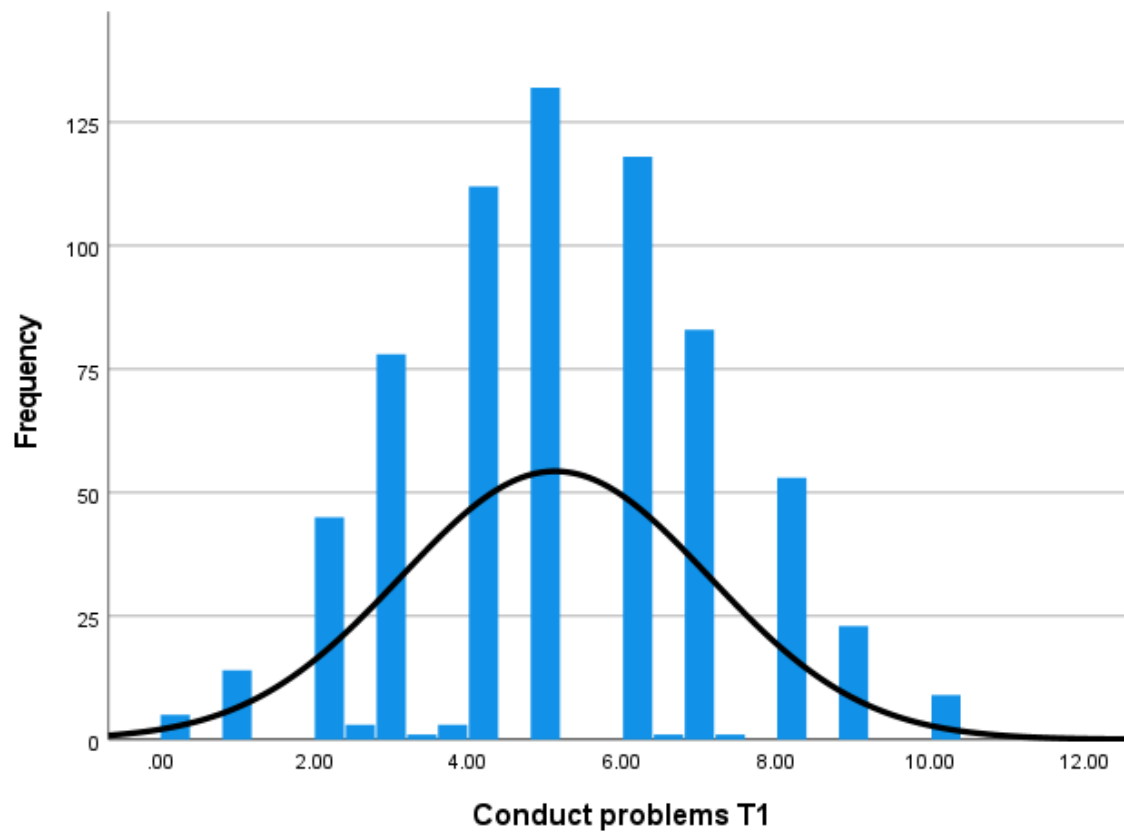
Appendix Figure 5. Histogram for the SDQ peer problems scores at T1 (n=681, mean = 2.71, SD = 2.02)

Peer problems T1

Appendix D: Prevalence of missing items

Appendix Table 3. Prevalence of missing items in the SRDS at T1 and T2

Missing Items	SRDS T1		SRDS T2	
	Number	%	Number	%
0	568	82.4	443	64.3
1	86	12.5	56	8.1
2	13	1.9	14	2
3	8	1.2	1	0.1
4	4	0.6	0	0.0
5	3	0.4	1	0.1
6	1	0.1	0	0.0
7	1	0.1	1	0.1
8	0	0.0	0	0.0
9	1	0.1	1	0.1
10	1	0.1	0	0.0
11	0	0.0	1	0.1
12	2	0.3	1	0.1
13	0	0.0	0	0.0
14	1	0.1	1	0.1
15	0	0.0	2	0.3
16	0	0.0	0	0.0
17	0	0.0	1	0.1
18	0	0.0	0	0.0
19	0	0.0	166	24.1
Total	689	100.0	689	100.0

Appendix E: Timeframes for completing follow-up (T2) questionnaires

Appendix Table 4. Months between baseline (T1) and follow-up (T2) questionnaires for children in the STEER and signposting groups

Months between T1 and T2	STEER		Signposting	
	Frequency	%	Frequency	%
0-3 months	2	0.8%	1	0.4%
4 months	10	3.8%	12	4.6%
5 months	88	33.7%	73	27.8%
6 months	116	44.4%	108	41.1%
7 months	32	12.3%	23	8.7%
8 months	5	1.9%	20	7.6%
9+ months	8	3.1%	26	9.9%
Total	**261**	**100.0%**	**263**	**100.0%**

Appendix E: Recruitment documents

Information Sheet for Children

Information for children

What are we doing
The STEER programme is designed to help children like you. It is being funded by the Youth Endowment Fund (YEF).
It can help you with school and help make sure you are safe.
We are doing a study to see whether STEER helps children and how it could be improved.

What will you get
If you agree to take part in this study you will either be:
1)   Offered a mentor who will meet up with you and give you advice
Or you will be:
2)   Given advice and told about places where you may find other support that might be helpful for you.
Whether you receive 1) or 2) above will be decided randomly. This is so that we can see if there are any differences based on the support people receive.

Who we are
We are Cordis Bright, a research organisation. Cordis Bright is called a 'controller' because it looks after your information. Contact details of key team members are below.

Contact

Project Manager: Suzie Clements,
Email: suzieclements@cordisbright.co.uk Tel: 020 7330 9170

Email: Colinhorswell@cordisbright.co.uk Tel: 020 7330 9170

What will you need to do
If you agree take part in the study, someone from STEER will ask you some questions about how you are feeling and things you have done in the past. This should take about 30-40 minutes.
They will ask you these questions at the start of the study before you get any advice or support.
They will also ask you these questions again around six months later.

6.   Information we collect
If you agree to take part in the study, STEER will give us some information about you, like your name and date of birth. They will also give us information about things like how you are feeling and things you have done in the past.
STEER will also give us some information about the support you receive.

7.   How we keep you safe
If you feel upset by any of the questions you are asked, you should tell your parent or carer or the person from STEER that you are working with.
The answers you give will be kept secret between us and the researchers unless we think that you or someone else might be at risk of harm. If this happens then we will try to talk to you first about why we want to tell another person or organisation about what you told us.

8. How we use your information

We will use the information you and other children give us to find out how much STEER has helped people. We will write a report about what we find. The report will not include your name or any other information that could identify you.

The report will go on to the YEF's website and anyone will be able to read it. We might also put it on our website or in articles and presentations.

9. How we comply with the law

We will only use your information if the law says it's ok. Because this study is interesting and important to lots of people, the law says we can use your information.

We will always keep your information safe. During the study, we only let our research team look at your information.

10. After the study finishes

When we finish the study, we'll give your information to the YEF and they will become the 'controller' of it. They will keep your information in a safe place called the YEF archive.

The picture on the next page of this sheet explains more about what will happen to your information. You can ask the person you are discussing this with about this and the picture.

You can also see more information in the Privacy Notice that has been given to your parent/the person who cares for you.

11. Do you want to take part?

You can decide whether or not you want to take part in the STEER study.

We want lots of people to take part because this helps us to understand what makes a difference for children.

You do not have to take part in the study – it is up to you. If you do not want to take part, tell your parent or guardian, or the person from STEER you are working with.

If you decide not to take part in the study, you can still get all the support you would normally have. However, you won't be able to take part in STEER.

We will also talk to your parent or the person who cares for you, so they know we have asked you about this. We will also ask for their permission to let you take part.

12. What happens if you change your mind?

You can change your mind about taking part in the study at any time.

If you change your mind, tell your parent or guardian, or contact Suzie the project manager. You will still be allowed to take part in STEER.

Once your information goes into the YEF archive it can't be deleted because it needs to be used for future research.

13. How long will we keep your information?

After we have given the information to YEF, we will take all names and other personal details out of the information held by Cordis Bright so no one will be able to know who took part in the study. We will keep this information for six years after we have finished the final report.

Information will be kept safely in the YEF archive for as long as it is needed for future research.

14. Your legal rights

The law gives you rights over how we can use your information. You can find full details of these rights in the information sheet the STEER practitioner has given to your parent or carer and in YEF's archive privacy notice:https://youthendowmentfund.org.uk/wp-content/uploads/2021/07/YEF-Data-Guidance-Participants.pdf
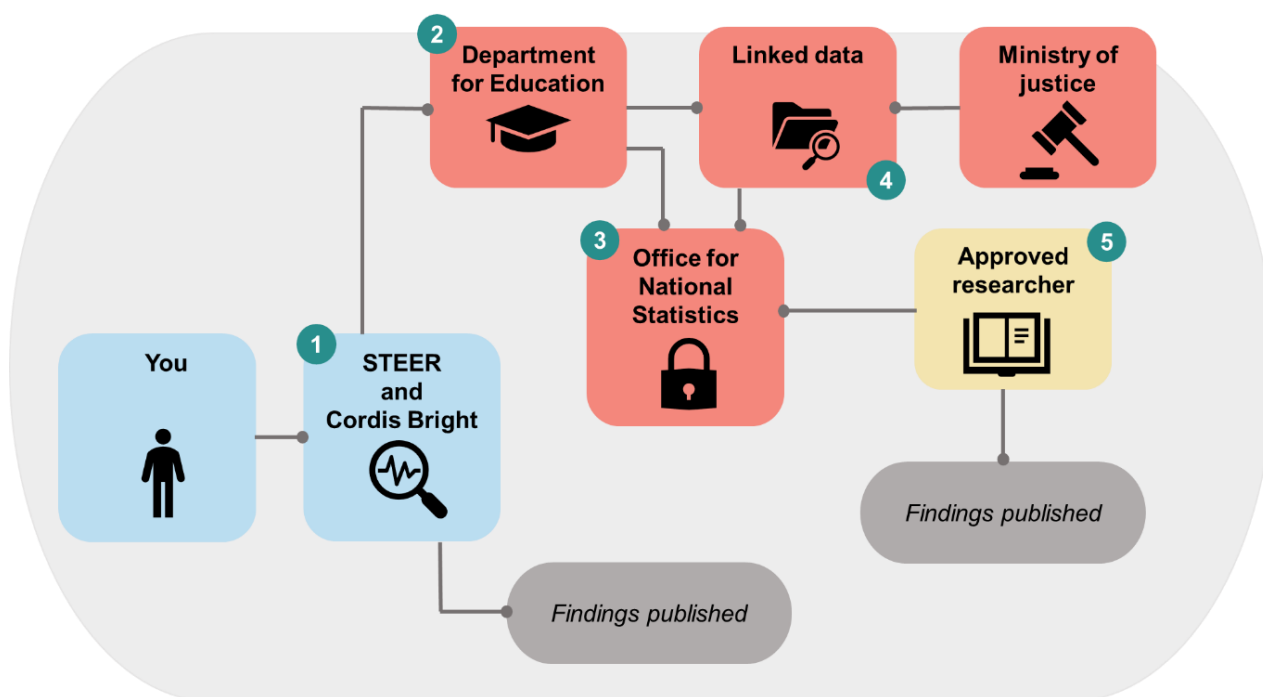
15. Questions?

If you have any questions, you can ask the person who is talking to you about this. You can also contact Suzie, the Project Manager. Her contact details are in the box on the first page.

If you have any questions about how we will use your information, you can ask our Data Protection Officer, Colin. His contact details are in the box on the first page.

You also have the right to make a complaint to the Information Commissioner's Office (ICO). You can find more information about the ICO and how to make complain to them on their website https://ico.org.uk/make-a-complaint/.

How your information will be used

- Information is collected from you and other children as part of the study to see if STEER is helping you.
- Personal information (like your name or date of birth) is removed from your records. After this, no one will be able to know who you are when looking at the information.
- The information will then be held in a safe place called the YEF archive by the Office for National Statistics (ONS). No one can access it without approval.
- The Department for Education and the Ministry of Justice will put together information about you that they already hold. This will be sent to the ONS to safely match to your information in the YEF archive.
- Only researchers that YEF work with will be allowed to safely access your information to see if STEER helped people.

An evaluation of the STEER programme. Agreement statement for children

I confirm that:

    I understand the information sheet

    I have had an opportunity to ask questions

    I have enough information to make a decision about whether to take part in the study

    I understand that I am free to withdraw from the study at any point.

I agree to take part in this study

Signed (participant)	Date
Name in block capitals (participant)	
Signature of STEER practitioner	Date
STEER practitioner Name in block capitals Tel: Email:	

Evaluation of Salford Foundation's STEER Programme

Information for children

1. What are we doing

We are doing a study of children taking part in Salford Foundation's STEER programme to find out how it might help children with their wellbeing and behaviour, and to prevent offending or re-offending. The study is being funded by the Youth Endowment Fund (YEF), for more information see: https://youthendowmentfund.org.uk/.

This information sheet contains information about who we are, what we are doing, and why we are doing it. It also explains how we will use your child's/the child you care for's personal information if you agree for them to take part in this study.

2. Who we are

This study is being organised by an independent research organisation Cordis Bright. You can find more information on Cordis Bright by visiting the website www.cordisbright.co.uk .

When we collect and use your child/the child in your care's personal information as part of the study, we are the controllers of the personal information. This means we decide what personal information to collect and how it is used. Contact details of team members are below.

Contact

Project Manager: Suzie Clements,
Email: suzieclements@cordisbright.co.uk Tel: 020 7330 9170

Email: Colinhorswell@cordisbright.co.uk Tel: 020 7330 9170

3. What will your child/the child you care for get?

If you agree to your child/the child you care for taking part in STEER and the STEER study, they will either be:

1. Offered a mentor who will deliver a tailored support plan over a period of about six months.

Or they will be:

2. Signposted to other services and given support to make sure they are safe. This will consist of two check-in sessions (one now and one in six months' time) which will include an assessment of needs.

Whether they receive 1) or 2) above will be decided randomly. This is so that we can see if there are any differences based on the support people receive. See the picture below which explains this.

Group 1 – Offered a mentor who will deliver a tailored support plan over about 6 months

STEER– Population is split into 2 randomly

Changes for both groups are measured

Young people referred into STEER

Group 2 – Signposted to other services and given support to make sure they are safe
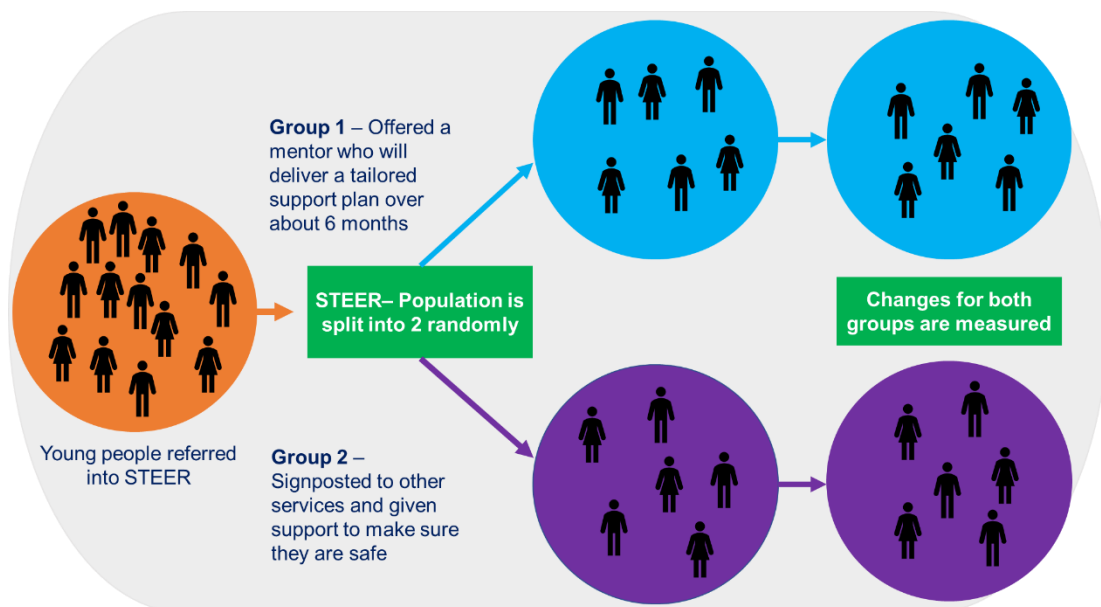
4. Who has reviewed this study?

This study has been reviewed and approved by the University of Greenwich Research Ethics Committee. The approval ID is: 21.3.7.4.

Why has your child/the child you care for been invited to take part?

Your child/the child you care for has been asked to take part in this study because they are eligible to take part in the STEER programme.

5. Do they have to take part in the STEER study?

If you do not want your child/the child you care for to take part in the study, they do not have to. It's a decision you may want to take together.

We would like as many children as possible to take part to improve our understanding about what makes a difference for children.

If your child/the child in your care chooses not to take part in the study, all the usual services will continue to be available to you. However, STEER will not be available to them.

6. What happens if your child/the child in your care takes part?

If your child/the child in your care takes part in the study, they will be asked to complete two questionnaires about their wellbeing and behaviour.

They will be asked to fill out the first questionnaire at the start of the study before they are randomly allocated to group 1) or 2) explained above and before they receive any support.

They will then be asked to fill out a similar questionnaire around six months later to see if anything has changed. This will help us to understand the difference STEER is making to childrens' lives.

A STEER member of staff will help support your child/the child you care for to answer the questions where appropriate. Each questionnaire will take around 30-40 minutes to complete.

If you agree for your child/the child you care for to take part in this study, we will also access records collected by the STEER programme, for example, information about their background and what support they have received.

7. How do we keep your child/the child you care for safe?

Occasionally, someone may feel upset about a question or issue that arises during the study. If you or your child/the child you care for feel upset by any of the questions they are asked as part of this study, you should tell their STEER worker, our study manager Suzie (see box above for contact details) or our safeguarding lead Kam Kaur, who is contactable at kamkaur@cordisbright.co.uk or on 020 7330 9170.

If you or your child/the child you care for do not feel able to ask us for help, we encourage you to make contact with an external support service such as The Samaritans (Tel. 116 123, www.samaritans.org) or Childline (Tel. 0800 1111, www.childline.org.uk).

We will keep the information that your child/the child you care for shares with us secret. However, if they tell us something that makes us think they or others might be at risk of harm we will report this to the relevant authorities. If this happens then we will try to discuss it with them first.

You can find more information in our Safeguarding Policy. This can be viewed here: https://www.cordisbright.co.uk/news/safeguarding-and-protecting-children-young-people-and-adults-at-risk

8. How will we use the personal information that we collect?

We will use the information that your child/the child you care for gives us to find out how well the STEER programme has worked and to write a report about our findings.

The Privacy Notice provided along with this sheet provides more information about what will happen to this information after the study. This is also summarised in a picture on the next page of this sheet.

9. What happens if you change your mind?

You and your child/the child you care for can change your minds about whether they take part in the study (and have their information sent to the YEF archive) at any time before the study comes to an end in January 2025.

To withdraw from the study, contact Suzie, the Project Manager using the details provided in the box at the start of this information sheet. You do not have to give a reason and your child/the child you work with will still be allowed to take part in STEER if they have already started work with a mentor.

If you change your mind, please tell us as soon as possible. After two weeks following completion of the second questionnaire at around six months it might no longer be possible to delete the personal information we have already collected from your child/the child you care for. This is because we will have used their information and those of other participants to carry out part of our study and to write a research report. If it is too late to delete the information already collected from your child/the child you care for from the study, they can still withdraw from the YEF archive.

Once information goes into the YEF archive after January 2025 it can no longer be deleted because that would affect the quality of the archived data for use in future research.

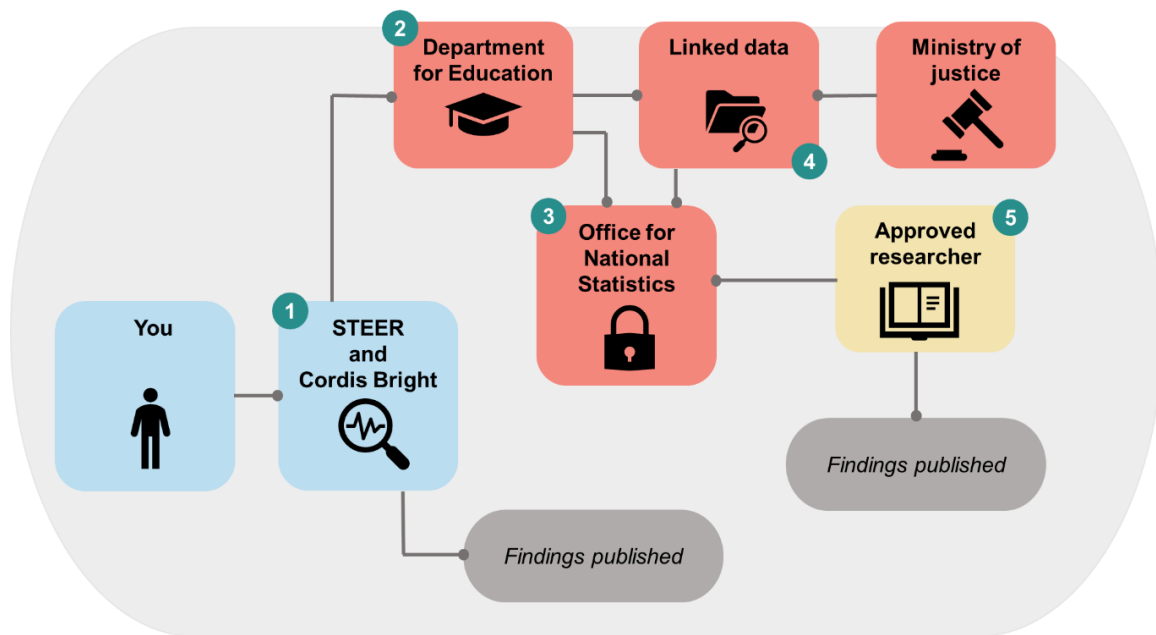**10. Feedback, queries or complaints**

If you have any questions about anything to do with the study, you can contact the STEER practitioner who has talked about this with you or Suzie, the study project manager. Her details are in the box on the first page of this sheet.

If you have any feedback or questions about how we use personal information, or if you want to make a complaint, you can contact Colin our Data Protection Officer using the details provided in the box at the start of this information sheet.

We always encourage you to speak to us first, but if you remain unsatisfied you also have the right to make a complaint at any time to the Information Commissioner's Office (ICO), the UK supervisory authority for data protection issues: https://ico.org.uk/make-acomplaint/ .

How your information will be used

- Information is collected from you and other children as part of the study to see if STEER is helping you.
- Personal information (like your name or date of birth) is removed from your records. After this, no one will be able to know who you are when looking at the information.
- The information will then be held in a safe place called the YEF archive by the Office for National Statistics (ONS). No one can access it without approval.
- The Department for Education and the Ministry of Justice will put together information about you that they already hold. This will be sent to the ONS to safely match to your information in the YEF archive.
- Only researchers that YEF work with will be allowed to safely access your information to see if STEER helped people.

An evaluation of the STEER programme. Agreement statement for children

I confirm that:

    I understand the information sheet

    I have had an opportunity to ask questions

    I have enough information to make a decision about whether to take part in the study

    I understand that I am free to withdraw from the study at any point.

I agree my child/the child I care for can take part in this study.

Name of participant/child (block capitals)	
Signed (adult on behalf of participant)	Date
Name of adult (block capitals)	
Signature of STEER practitioner	Date
STEER practitioner's contact details	
STEER practitioners name (block capitals) Tel: Email:	

Appendix F: Privacy Notice

We are carrying out a study of children taking part in Salford Foundation's STEER programme to try to find out how the programme might help children in the future. The study is being funded by the Youth Endowment Fund (YEF) – see www.youthendowmentfund.org.uk for more information.

This study is being organised by an independent research organisation Cordis Bright. You can find more information on Cordis Bright by visiting the website www.cordisbright.co.uk.

When we collect and use participants' personal information as part of the study, we are the controllers of the personal information, which means we decide what personal information to collect and how it is used.

This Privacy Notice explains how we will use and protect the personal information we collect from your child/the child you care for. Key research team members contact details are below.

> Contact
>
> **Project Manager: Suzie Clements**,
> Email: suzieclements@cordisbright.co.uk Tel: 020 7330 9170
>
> Email: Colinhorswell@cordisbright.co.uk Tel: 020 7330 9170
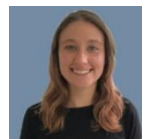
How will we use the personal information that we collect?

Data protection laws require us to have a valid reason to use your child's/the child you care for's personal information. This is referred to as our 'lawful basis.' We rely on the public interest lawful basis to use their personal information. This means we will only use more sensitive information (such as information about their health, ethnic background, or any criminal offence information) if it is necessary for research purposes which are in the public interest.

We will use the information that your child/the child you care for gives us to find out how well the STEER programme has worked and to write reports about our findings.

The reports will not contain any personal information about your child/the child you care for and no one will be able to identify them from the reports. The reports will be published on the YEF's website and we might also use the reports on our website. We may also include findings from the reports in articles that we write or in presentations.

Any personal information that your child/the child you care for gives us will be stored securely and kept secret. The only time we may share this personal information with another person or organisation is if your child/the child you care for says something that makes us concerned about them or about someone else. Our Safeguarding Policy has more information about steps that we might take if this happens. This can be seen here: https://www.cordisbright.co.uk/news/safeguarding-and-protecting-children-young-people-and-adults-at-risk.

What happens to personal information after the study?

Once we have finished the study, we will do the following:

- Share all of the information we have gathered about everyone who has taken part with the Department for Education (DfE). The DfE will replace all information that could identify the children (their name, gender, date of birth, home address) with an identification number . Once this has been done, it is no longer possible to identify any individual child from the study data. This process is called pseudonymisation.
- Once information is transferred to the DfE, we hand over control to the YEF for protecting your personal information. The DfE will transfer the pseudonymised information to the YEF archive . The YEF is the 'controller' of the information in the YEF archive. By maintaining the archive and allowing approved researchers to access the information in the archive, the YEF is performing a task in the public interest, and this gives the YEF a lawful basis to use personal information.
- Information in the YEF archive can only be used by approved researchers to explore whether STEER, and other programmes funded by YEF, had an impact over a longer period of time. Using the unique identification numbers added to the data by the DfE it will be possible to link the records held in the YEF archive to other information held by the Department for Education and Ministry of Justice. This will help approved researchers to understand the long-term impact of the STEER programme because they can find out, for example, whether it reduces a child's likelihood of being excluded from school or becoming involved in criminal activity.

How will we protect your child/the child you care for's information?

We will do a number of things to protect your child's/the child you care for's personal information during the study, including:

Limiting access to a few researchers who need the information to conduct the study.

Keeping personal details such as name and address separate from all other data and linking these using a unique number.

Keeping information on a secure safe server and making sure information is regularly backed up so it is not lost.

We will not transfer personal data outside the UK.

How is information in the YEF archive protected?

The YEF has strong measures to protect the information in their archive. The YEF archive is protected by the Office for National Statistics' 'Five Safes' framework. The information can only be accessed by YEF approved researchers in safe settings and there are strict rules about how the information can be used. All proposals must be approved by an ethics panel. Information in the YEF archive cannot be used by the police or the Home Office for immigration enforcement purposes.

You can find more information about the YEF archive and the Five Safes on the YEF's website https://youthendowmentfund.org.uk/evaluation-data-archive/. YEF's data archive privacy statement is also available here: https://youthendowmentfund.org.uk/wp-content/uploads/2021/07/YEF-Data-Guidance-Participants.pdf. We encourage all children, parents and carers to read the YEF's guidance for participants before deciding to take part in this study.

How long will the information be kept for?

After we have given the information to YEF, we will take all names and other personal details out of the dataset held by Cordis Bright so no one will be able to know who took part in the study. We will keep this information for six years after we have finished the report.

The YEF will keep information in the YEF archive for as long as it is needed for research purposes. This is allowed under data protection laws because it is in the public interest. The YEF will carry out a review every five years to see whether it is likely that the data will be used for future research and to see whether it still makes sense to keep the information in the archive.

What are your data protection rights?

You/You and your child/You and the child in your care have the right to:

Ask for access to the personal information that we hold about them;

Ask us to correct any personal information that we hold about them which is incorrect, incomplete or inaccurate.

In certain circumstances, you also have the right to:

Ask us to erase the personal information where there is no good reason for us continuing to hold it – please read the information in the section about the time limits for requesting deletion of personal information;

Object to us using the personal information for public task purposes;

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

If you would like to do any of the above during the study period, please contact Suzie our Project Manager, or Colin our Data Protection Officer using the details provided earlier. We will usually respond within one month of receiving your request.

If you would like to do any of the above after the study has finished, please contact the YEF. Further information and their contact details are available in YEF's data archive guidance here: https://res.cloudinary.com/yef/images/v1625734531/cdn/YEF-Data-Guidance-Participants/YEF-Data-Guidance-Participants.pdf .

If you ask us to do any of the above, we may need to ask for more information to help us confirm the identity of your child/the child you care for. This makes sure that personal information is not shared with a person who has no right to receive it. We may also you for more information to make sure we can respond more quickly.

Time limits

If you decide that you would like us to delete your child/the child you care for's information from the study, you should tell us as soon as possible.

After two weeks following completion of the second set of questions (at around six months – see the information sheet for parents/carers for more information) it might no longer be possible to delete the

personal information we have already collected from your child/the child you care for. This is because we might have used their information, along with all of the information we have gathered from the other participants, to carry out part of our study and to write a report.

Once information goes into the YEF archive after January 2025 we can no longer delete it. You will need to apply to the YEF (see contact details in the section above), who will review applications for deletion on an individual basis.

Other privacy information

Categories of personal information we will collect include:

First name
Surname
Date of Birth
Home address
Alternative address (if appropriate)
Telephone number
Email address

What personal information will be shared?

We only ever use your child's/the child you care for's personal information if we are satisfied that it is lawful and fair to do so.

Section above explains how we share data with the Department for Education and the YEF.

We may also share personal information with the police so that they can tell us what information they have about the child from the year before they took part in the study and in the year after they agreed to take part in the study.

We will not transfer your personal data outside the UK.

What if I have any questions, feedback, or complaints?

If you have any feedback or questions about how we use personal information, or if you want to make a complaint, you can contact Suzie, the Project Manager or Colin, the Data Protection Officer using the details provided earlier.

We always encourage you to speak to us first, but if you remain unsatisfied you also have the right to make a complaint at any time to the Information Commissioner's Office (ICO), the UK supervisory authority for data protection issues: https://ico.org.uk/make-acomplaint/ .

Appendix G: IPE topic guides

Interviews with staff

About you

Note to interviewer: confirm participants name, role and organisation.

1. Please could you describe your role in the STEER programme? Prompts: Specific responsibilities of their role, if and how they interact with children, parents/carers, and other stakeholders.

The STEER model

2. The next few questions are designed to get an understanding of your views about the context and rationale behind the STEER model, and how children are referred into the programme.

Demand and rationale

3. Do you think the STEER programme is needed in Greater Manchester? Why is it needed and what gap is it seeking to address? Prompts: Does this demand or need differ across the different areas STEER is working in? If so, in what ways?

Reach, referrals and engagement

4. Who do you think is the target cohort for STEER?

5. Do you think that STEER is successfully reaching these children? Why do you say this?

6. Do referral rates vary across the different areas STEER is working in (Bolton, Manchester, Salford, Trafford, Wigan)? If yes, why?

7. Are there any other groups who you think would benefit from STEER who are not currently being reached? Why do you think this?

8. How well does STEER reach children from minoritised and marginalised backgrounds, for example from ethnic minority backgrounds? If well, how does it achieve this? If it could be better, what actions are needed?

9. What do you think has worked well helping STEER reach its intended audience? What could have been improved? Prompts: e.g. effectively linking with multi-agency groups, clear communication to referral partners, clear and easy to use referral forms, responsiveness of STEER staff to referrals?

10. Are the pathways for identification, referral and assessment into and through STEER working well? If yes, why? If no, how could things be improved?

11. Is it clear why and how decisions have been made in terms of:

    a. Eligibility for STEER (entrance criteria)?
    b. Decisions for what support is provided for children and families?
    c. Safe exit criteria?
    d. What is working well and what could be improved?

I'd now like to talk to you about how STEER has engaged with children after they have been referred into the programme.

12. How well do you think STEER has engaged with children after the referral stage (i.e. from the home visit to completion of the programme)? What has worked well? What could be improved in engaging children? Prompts: Are there any aspects of STEER which have been effective in engaging children? Are some groups of children more engaged with STEER than others? If so, why do you think this is?

13. Have any children dropped out of STEER during the programme? If yes, why do you think this? Prompt: Is there anything that you think could support children to stay engaged?

Implementation and delivery of STEER

The next set of questions are designed to understand how effectively you think STEER is being implemented across the areas it is operating in. Prompt reminders of what STEER entails:

- 1-hour weekly 1-2-1 mentoring including mandatory (around safety planning, relationships mapping, healthy relationships, exploitation, weapon carrying, attitudes and behaviours, goal setting) and optional sessions (around cannabis use, anger and aggression control, family conflict, and educational support).
- 1-hour weekly wrap-around casework and support (e.g. phone calls, advocacy with other agencies, multi-agency.)
- 14 hours of family support worker support over six months for families or care givers or the STEER cohort (including sessions on parenting skills, managing boundaries, communication strategies with children and professionals).

14. Which elements of STEER have been implemented most successfully? Which elements of STEER could be improved? Why? Prompts:

    a. How consistent is the quality of what's offered to children? Do experiences of support vary for different groups of children? If so, how and why do you think this is?
    b. Do you feel the resources available support the effective delivery of STEER?

15. In your view how useful has the STEER toolkit been in implementing STEER? Has STEER been rolled out in line with the toolkit? If yes, how do you know? If no, why is this? Prompts: How many sessions have been delivered to children? Is this in line with what is in the toolkit? What topics have been covered in the sessions, and does this match what is in the toolkit? Has anything else been delivered that is not currently in the toolkit?

16. How well has STEER been rolled out across the different areas? What is working well? What could be improved? Why do you say this? Prompts:

    a. How effectively has it embedded across different local systems?
    b. How well is STEER working with partners?
    c. Does this differ across areas? If so, in what ways? Why do you think this is?
    d. Have there been any key factors that have supported the effective delivery of STEER? For example, at:
    e. An organisational level (i.e. staffing, Salford Foundation)?
    f. A local or community level (i.e. Greater Manchester)? e.g. level of need, system structures, readiness for change, existing referral pathways, partnership working
    g. A national level (i.e. YEF, government, funding, etc.)?

17. Have there been any challenges or barriers to the effective delivery of STEER? For example, at:

    a. An organisational level (i.e. staffing, Salford Foundation)?

b. A local or community level (i.e. Greater Manchester)? e.g. level of need, system structures, readiness for change, existing referral pathways, partnership working
c. A national level (i.e. YEF, government, funding, etc.)?
d. If so, how were these addressed?

Impact

18. The next set of questions focuses on exploring the impact you think STEER is having.

19. From your perspective, what impact is STEER having on: Children? Families (parents/ carers)? The wider system (e.g. local youth justice, education, and children social care services)?

20. Do you think the impact of STEER varies for different groups of children? If so, how and why do you think this is? Prompt: i.e., child's ethnicity, age, gender etc. Does this vary across the different areas STEER is working in?

21. Which aspects of the programme are making the most or least difference for children?

22. Prompts: Could anything make even more of a difference?

23. Have there been any unintended impacts, either positive or negative, resulting from the STEER programme? Prompt: If yes, do these differ depending on the child's characteristics and/ or experiences of the service?

Future delivery

24. Finally, these questions are designed to understand your views on the implications of scaling up STEER across the country.

25. Is there anything you'd like to change about STEER?

26. What do you think would be three key factors necessary for STEER to be successfully implemented in a new area? (either within Greater Manchester or beyond?)

27. What do you think are challenges with replicating and scaling up STEER in a new area? How could these challenges be addressed?

28. Is there anything else that you would like to tell us?

About you

1. Please could you describe your relationship to the STEER programme? Prompts: Have you referred into STEER? Do you work with children or children receiving support from STEER? Have you been involved in other ways?

Note to interviewer: Please use this question to get a sense of which questions the interviewee is best placed to answer and tailor the focus of the interview accordingly.

The STEER model

The next few questions are designed to get an understanding of your views about the context and rationale behind the STEER model and to understand how children are referred into the programme.

Demand and rationale

2. To what extent do you think there is local demand/ need for STEER and why? What gap is it seeking to address? Prompts: Does this demand or need differ across the different areas STEER is working in? If so, in what ways?

Referrals and target cohort

3. Who do you think is the target cohort for STEER?

4. Do you think that STEER is successfully reaching these children? Why do you say this? Prompts: Does this vary across the different areas that STEER is working in? Are there any other groups who you think would benefit from STEER who are not currently being reached? Why do you think this?

5. If yes, what do you think has worked well helping STEER reach its intended audience? If no, what do you think could have been improved? Prompts: e.g. effectively linking with multi-agency groups, clear communication to referral partners, clear and easy to use referral forms, responsiveness of STEER staff to referrals?

6. How well is STEER reaching children from minoritised and marginalised backgrounds including those from minority ethnic backgrounds? If well, how is it achieving this? If not well, what could be done to improve? Prompts: what has worked well or could be improved in helping STEER reach children from minoritised ethnic backgrounds?

7. Have you referred a child to STEER? If yes, how did you find this process? Did anything work particularly well? Could anything be improved?

8. Are the pathways for identification, referral and assessment into and through STEER working well? Is it clear why and how decisions have been made in terms of:

Eligibility for STEER (entrance criteria)?

9. Decisions for what support is provided for children and families?

10. What is working well and what could be improved?

Implementation and delivery of STEER

The next set of questions are designed to understand how effectively you think STEER is being implemented.

As you may know, STEER is a programme that provides mentoring for children between the ages of 10-17 years who are at risk of serious youth violence and child criminal exploitation across Bolton, Salford, Trafford, and Wigan. It involves:

- 1-hour weekly 1-2-1 mentoring including mandatory (around safety planning, relationships mapping, healthy relationships, exploitation, weapon carrying, attitudes and behaviours, goal setting) and optional sessions (around cannabis use, anger and aggression control, family conflict, and educational support).
- 1-hour weekly wrap-around casework and support (e.g. phone calls, advocacy with other agencies, multi-agency.
- 14 hours of family support worker support over six months for families or care givers or the STEER cohort (including sessions on parenting skills, managing boundaries, communication strategies with children and professionals).

11. Do you have any insights into these key activities of STEER? If so, do you think any of these elements have been implemented particularly successfully? Could anything have been improved?

12. How well has STEER been rolled out across the different areas (i.e. Bolton, Manchester, Salford, Trafford, Wigan)? What is working well? What could be improved? Why do you say this?

    Prompts: How effectively has it embedded across different local systems? How well is STEER working with partners? Does this differ across areas? If so, in what ways? Why do you think this is?

13. Have there been any key factors that have supported the effective delivery of STEER, either at an individual local authority level or across all the different local authority areas that STEER is operating in? For example, at:

    a. An organisational level (i.e. staffing, Salford Foundation)?

    b. A local or community level (i.e. Greater Manchester)? e.g. level of need, system structures, readiness for change, existing referral pathways, partnership working

    c. A national level (i.e. YEF, government, funding, etc.)?

14. Have there been any challenges or barriers to the effective delivery of STEER, either at an individual local authority level or across all the different local authority areas that STEER is operating in? For example, at:

    a. An organisational level (i.e. staffing, Salford Foundation)?
    b. A local or community level (i.e. Greater Manchester)? e.g. level of need, system structures, readiness for change, existing referral pathways, partnership working
    c. A national level (i.e. YEF, government, funding, etc.)?

    If so, how were these addressed?

Impact

The next set of questions focuses on exploring the impact you think STEER is having.

15. Do you have any insight into the impact of STEER? If so, what impact do you think STEER is having on: Children? Families (parents/ carers)? The wider system (e.g. local youth justice, education, and children social care services)?

16. Do you think the impact of STEER varies across different groups of children? If so, how and why do you think this is? Prompt: i.e., child's ethnicity, age, gender etc. Does this vary across the four areas in Greater Manchester?

17. Do you have any insights into what aspects of the programme are making the most or least difference for these groups? Prompts: Could anything make even more of a difference?

18. Have there been any unintended impacts, either positive or negative, resulting from the STEER programme? Prompt: If yes, do these differ depending on the child's characteristics and/ or experiences of the service?

Future delivery

Finally, these questions are designed to understand your views on the implications of scaling up STEER across the country.

19. Is there anything you'd like to change about STEER?

20. What do you think would be three key factors necessary for STEER to be successfully implemented in a new area? (either within Greater Manchester or beyond?)

21. Do you think there would be any challenges with trying to replicate and scale up STEER in a new area? What are these and how could they be addressed?

22. Is there anything else that you would like to tell us?

About you

1. Before we get going, I'd like to hear a little bit about you. Can you tell me what you like doing in your free time?

Introduction to STEER

2. I'd now like to talk to you about when you first heard about STEER.

3. How did you first hear about STEER? How did you find out about it? Did someone from STEER come and talk to you about it?

4. What worked well about getting started with STEER? Was there anything that could have been done differently?

   Prompts: Did you need more or less information?

5. What helped you decide to get involved with the programme? Was there anything that could have been improved?

Mentoring

6. I'd now like to talk to you about what you've been doing with your mentor.

7. How well do you get on with your STEER mentor? Why do you say this? Prompts: Are they someone you can turn to for help? Do you trust them?

8. What activities have you done with your mentor? What sort of things have you learned about? Prompts: Group/ individual activities, how long did they last etc

9. How did you find your sessions with your mentor? Was there anything you liked most? What could have made your sessions better? Prompts: What about the time or place of the sessions?

10. Since you started working with your mentor, have you missed any sessions or have there been times when you've met with them less often?

    If yes: Can you tell me a bit more about why this happened? Have you started meeting more regularly now? Was there anything that you found particularly helpful for starting to meet regularly again?

Impact of STEER

11. I'd now like to talk to you about whether you think the support from your STEER mentor has made a difference to your life.

12. What have you been working on or towards during your time with your mentor?
    Prompts: Did you have any specific goals in mind when you started? What were you hoping to get out of working with your mentor? E.g. help with school attendance, help with managing emotions, help with relationships, help with social and communication skills, reduced contact with the police, thinking about the future/employment opportunities? Have your goals changed?

13. Since you started meeting with your mentor, have you noticed any changes in:

    a. Your emotions? Prompts: Have you noticed any changes in how you feel? Are you finding it easier or harder to manage your emotions?

b. Your behaviours? Prompts: Are you getting into trouble less/ more? Do you understand the risks and consequences of your actions better now?

c. Your friendships? Prompts: Have your friendships changed at all? Are you still spending time with friends who might have got you into trouble before? Have you made any new friendships at home, in the community, or at school?

d. Your family? Prompts: Are you getting on better/ worse with your family? Is it easier/ harder to speak to them?

e. How are you getting on in school? Prompts: How do you feel about school now? Are you enjoying school less/ more now? Are you more/ less involved in school activities? Are you getting along better/ worse with your teachers?

f. Things outside of school? Prompts: Are you more aware of things you can do outside of school? Do you feel like you want to get involved with them?

g. Anything else?

14. What has helped make these changes? Prompts: Has it helped to have someone to talk to like your STEER mentor? Have they encouraged you to make these changes in any way? Are there any particular experiences you have shared with mentor that you think have been helpful? Have any sessions been particularly helpful?

15. Is there anything else you would like to have learnt or learnt more about during your time with your mentor? Is there anything you would want to change about STEER? Why?

Looking to the future

16. Finally, how do you feel about the future and the options you have? Do you have any plans that you're excited about? Has this changed at all since your work with your STEER mentor? Prompts:

[If support ending soon]: How do you feel about nearing the end of the STEER programme? Is there any further support you might find helpful after you've finished working with your mentor?

[Depending on age and school year]: How are you feeling about the next school year? Are you more aware of the options that are available to you? Do you feel more confident in applying for things? Do you understand the application processes for different jobs or education opportunities? Do you have any hobbies or interests you're excited about?

17. Would you recommend STEER to other children like you? Why?

18. Is there anything else that you would like to tell us?

Appendix H. YEF Security Rating

Rating	Design	MDES Outcome: Threshold*	Attrition	→ Initial score	→ Adjustments	Final score
5 🔍	Randomised design	Offending: <=0.1 SDQ tot: <= 0.3 Other: <= 0.2	0-10%	5	0	
4 🔍	Design for comparison that considers some type of selection on unobservable characteristics (e.g. RDD, Diff-in-Diffs, Matched Diff-in-Diffs)	Offending: 0.11 – 0.19 SDQ tot: 0.31 – 0.39 Other: 0.21 – 0.29	11-20%			
3 🔍	Design for comparison that considers selection on all relevant observable confounders (e.g. Matching or Regression Analysis with variables descriptive of the selection mechanism)	Offending: 0.2 – 0.29 SDQ tot: 0.4 – 0.49 Other: 0.3 – 0.39	21-30%			3
2 🔍	Design for comparison that considers selection only on some relevant confounders	Offending: 0.3 – 0.39 SDQ tot: 0.5 – 0.59 Other: 0.4 – 0.49	31-40%			
1 🔍	Design for comparison that does not consider selection on any relevant confounders	Offending: 0.4 – 0.49	41-50%			

		SDQ tot: 0.6 – 0.69 Other: 0.5 – 0.59							
0 🔍	No comparator	Offending: >= 0.5 SDQ tot: >= 0.7 Other: >= 0.6	>50%						160

*MDES requirements vary by outcome measurement. Offending: Offending data collected through self-report or admin data; SDQ tot = SDQ total difficulties score; Other: all other outcomes, incl. SDQ externalising and internalising