NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

DRAFT GUIDELINE

Child abuse and neglect: recognising, assessing and responding to abuse and neglect of children and young people

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Contents

Introduction

The Department of Health and Department for Education asked NICE to produce this guideline on child abuse and neglect (see the scope).

Cruelty to children is a criminal offence, and abuse and neglect can have serious adverse health and social consequences for children and young people, which can persist in to adulthood. In the 1-year period from 1 April 2015 to 31 March 2016 there were 621,470 referrals to children's social care, although not all of these resulted in substantiated cases of abuse or neglect (Characteristics of children in need in England 2015 to 2016 Department for Education). During this period 50,310 children and young people were the subject of a 'child protection plan', with the most common reasons cited as neglect (46%) and emotional abuse (35%).

Practitioners working in health and social care, the police and those taking the 'lead professional' role in services such as education, have an important part to play in addressing abuse and neglect. This guideline aims to support practitioners in this role by providing evidence-based recommendations on 'what works' in recognition, assessment, early help and response to child abuse and neglect. It covers physical, emotional and sexual abuse, and neglect as defined in the statutory guidance Working together to safeguard children. It also covers abuse cited in the 'Particular safeguarding issues' section of Working Together including child sexual exploitation, female genital mutilation, forced marriage and child trafficking.

This guideline makes recommendations about practice in relation to children and young people (under 18, including unborn babies) at risk of, experiencing, or who have experienced, abuse or neglect and their parents and carers. The guideline does not cover interventions provided to people who are suspected or known to abuse children or young people of whom they are not the parent, step-parent, partner of a parent, family member or carer. Abuse perpetrated by this group will be in scope, but interventions for this group will not. It also does not cover practice in relation to adults (aged 18 or older) who experienced abuse or neglect as children.

This guideline aimed to build on the recommendations in child maltreatment which provided a summary of clinical features associated with child maltreatment (alerting features) that may be observed when a child presents to healthcare professionals.

The current guideline extends coverage of alerting features to those which may be observed by other professional groups, and also covers assessment, early help and response. This guideline has also adapted some of the recommendations from the guideline on children's attachment.

When this guideline was started, we used the methods and processes described in the Social care guidance manual (2013). From January 2015, we used the methods and processes in Developing NICE guidelines: the manual (2014). The guideline has been developed by a guideline committee of practitioners, academics and experts by experience, advised by an expert reference group of children and young people.

Context

Legislation, policy and guidance

The principal legislative framework for recognising and responding to abuse and neglect is provided by the Children Act 1989. In particular:

- section 17, relating to 'children in need'
- section 20, regarding the duty to accommodate a child
- section 31, relating to care and supervision orders
- section 47, relating to reasonable cause to suspect children 'suffering, or likely to suffer, significant harm'.

'Harm' is defined in the Children Act 1989 as 'ill-treatment or the impairment of health or development'. There is no single definition of 'significant harm'. An amendment to the Act, included in section 120 of the Adoption and Children Act 2002 clarifies that the definition of harm includes 'impairment suffered from seeing or hearing the ill-treatment of another'.

The Children Act 2004 introduced further provisions to strengthen multi-agency working in child protection, in particular by introducing duties for local authorities to promote cooperation between relevant agencies. Section 53 of the Children Act 2004 also places a duty on local authorities to ask children about their wishes and feelings before determining what (if any) services will be provided.

The Children and Families Act 2014 introduced changes to the family court, including a 26-week time limit on care proceedings. The Children and Social Work Bill will also be a key piece of legislation in this area when it is enacted.

Policy and guidance

The 2015 revision of 'Working together to safeguard children' sets out the expectations on individual services to safeguard and promote the welfare of children. It also sets out the framework for executive level multi-agency arrangements to monitor the effectiveness of local services.

The Wood review of the role and function of local safeguarding children boards proposed a number of changes to executive-level multi-agency arrangements. These

are being taken forward in the Children and Social Work Bill. This guideline has endeavoured to use language which will be applicable regardless of the new arrangements.

Current practice

Recognition

While some abuse or neglect may be reported, it is more likely to be brought to the attention of services because of a child or young person's behaviour and demeanour or the behaviour of caregivers (It takes a lot to build trust': recognition and telling: developing earlier routes to help for children and young people Office of the Children's Commissioner; Daniel et al. 2010). Professionals in many services therefore need to be equipped to respond to indicators of abuse and neglect, but recognising them can be challenging. It can also be difficult for practitioners to translate known population risk factors, for example parental mental health problems, into an assessment of risk for a specific child or family (Daniel et al. 2010). The Department for Education describes an 'interplay of the multiple risk and protective factors' that makes 'maltreatment more or less likely' (Safeguarding children across services: messages from research on identifying and responding to child maltreatment). This means that a holistic assessment of a child or young person's situation is needed.

Assessment

There are 2 principal forms of assessment available for families experiencing difficulties: 'early help' for families with relatively low level or emerging needs and, for more complex needs, help provided under section 17 of the Children Act 1989. In both cases, the aim of assessment is to gather information about a child and family, and analyse their needs and any risk of harm. Statutory assessments must also decide whether the child or young person is a child in need, and/or is suffering or likely to suffer significant harm. If there is cause to suspect a child is experiencing, or likely to experience, significant harm, an investigation should be undertaken under section 47 of the Children Act 1989. Government guidance recommends that assessment should use a systematic approach, based on a conceptual model.

Despite the guidance available, health and social care practitioners can find it difficult to assess the level of need and risk experienced by children, young people and families. This includes determining whether a child or young person is at risk of 'significant harm' (Safeguarding children across services: messages from research on identifying and responding to child maltreatment). A comprehensive review of assessment practice found that some practitioners lacked confidence in their ability to analyse the data they had collected during an assessment (Cleaver et al. 2004). Practitioners find it harder to define and assess neglect and emotional abuse, leading to preventable delays in taking action (Developing an effective response to neglect and emotional harm to children). High thresholds for a specialist response can also deter professionals from identifying and responding to abuse and neglect (Noticing and helping the neglected child: literature review Department for Children, Schools and Families).

Response, including early help

Statutory guidance on multi-agency child protection practice (Working together to safeguard children Department for Education) emphasises that local areas should provide services to meet a spectrum of different levels of need. Various universal and targeted services address abuse and neglect at the early help stage. These include specific interventions such as home visiting and parenting programmes. Coordinating the work of multi-agency partners can be challenging. Most areas have established processes for early help assessment, and arrangements for multi-agency working such as Team Around the Child/Family processes. However, models of early help, and the extent to which they are embedded in practice, vary nationally. Challenges also remain regarding, for example, which practitioners feel able to take on the lead professional role in these arrangements (Exploration of the costs and impact of the Common Assessment Framework Department for Education).

Families needing more intensive support under section 17 of the Children Act 1989 (relating to 'children in need') receive intervention from children's social care services, such as family support. Alternative care placements for children, such as foster or residential care, may also be considered. Specific time-limited interventions may also be provided to prevent abuse from recurring, and to address the psychological, behavioural and other consequences of abuse. These are delivered

by practitioners in services including psychology, psychiatry, health and education. Some interventions are aimed at the child or young person, for example cognitive behavioural therapy or psychotherapy, and others at the parent–child relationship or family, for example family therapy. However practitioners, managers and commissioners may often have insufficient evidence to know which of these interventions are most suitable for which children and families.

1 Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Practitioners should apply this guideline in light of the statutory functions of the agencies they work for under the Children Acts of 1989 and 2004. The context section provides more detail in relation to this. Practitioners should also use this guideline alongside the Department for Education's statutory guidance Working together to safeguard children and any guidance specific to their profession (for example the Department for Education's Keeping children safe in education and the General Medical Council's Protecting children and young people: doctors' responsibilities).

1.1 Principles for working with children, young people, parents and carers

Working with children and young people

1.1.1 Take a child-centred approach to all work with children and young people; involve them in decision-making to the fullest extent possible depending on their age and developmental stage.

1.1.2 Use a range of methods (for example, using drawing, books or activities if appropriate) for communicating with children and young people. Tailor communication to:

- their age and developmental stage
- any disabilities, for example learning difficulties or hearing and/or visual impairments

- communication needs, for example by using communication aids or providing an interpreter (ensure the interpreter is not a family member).

1.1.3 In all conversations with children and young people:

- explain confidentiality and when you might need to share specific information, and with whom
- be sensitive and empathetic
- listen actively and use open questions
- find out their views and wishes
- use plain language and explain any technical terms
- work at the child or young person's pace
- give them opportunities to stop the conversation or leave the room, and follow up if this does happen
- explain what will happen next and when.

1.1.4 Make sure the child or young person is comfortable with the environment in which conversations are being held and ensure they have privacy if they want to discuss any worries.

1.1.5 If your interaction with a child or young person involves touching them (for example, a medical examination) explain what you are going to do. For young people over 16, or children and young people who are under 16 but are Gillick competent, ask for their agreement first. If they do not agree and touching them is essential to their treatment, seek legal advice, unless the need for treatment is immediate. In all other cases respect their disagreement.

1.1.6 Produce a written record of conversations with children and young people and check that they agree with these (this could include both of you signing the record). Ensure their words are accurately represented, using their actual words if possible.

1.1.7 Share reports and plans with the child or young person in a way that is appropriate to their age and understanding.

1.1.8 When working with children and young people, always do what you say you are going to do. If circumstances change and this is no longer possible, explain why as soon as possible, and offer alternative actions.

1.1.9 When working with children and young people, clearly explain how you will work together with them and ensure they do not have unrealistic expectations.

1.1.10 Explain to the child or young person (if age appropriate) how and when they can contact you and what services are available out of hours. Give them contact details.

1.1.11 Agree with the child or young person how and when you will contact them, bearing in mind safety issues such as whether a perpetrator of abuse may have access to a young person's phone. Agree what will happen if you contact them and they do not respond, for example following up with their nominated emergency contact.

Working with parents and carers

1.1.12 Aim to build good working relationships with parents and carers to encourage their engagement and continued participation. This should involve:

- actively listening to them
- being open and honest
- avoiding blame, even if parents may be responsible for the abuse or neglect
- inviting, recognising and discussing any worries they have about specific interventions they will be offered
- identifying what parents are currently doing well, and building on this
- working in a way that enables trust to develop while maintaining professional boundaries
- being reliable, and available as promised
- keeping them informed, including explaining what information has been shared, and with whom

- being clear about the issues and concerns that have led to your involvement
- being clear about the legal context in which your involvement with them is taking place.

Working with other practitioners

1.1.13 Coordinate your work with practitioners in other agencies so that children, young people, parents and carers do not need to give the same information repeatedly.

Critical thinking and analysis

1.1.14 Think critically and analytically about cases and do not rely solely on protocols, proformas and electronic recording systems to support your professional thinking and planning.

1.2 Recognising abuse and neglect

Recommendations with an asterisk (*) are from NICE's guideline on child maltreatment. Wording has been adapted in some of these recommendations. Physical injuries and other clinical indicators are covered in child maltreatment.

In this section we have used a definition of 'consider' adapted from child maltreatment, as 1 of 2 levels of concern:

- to **consider** child abuse or neglect means that abuse or neglect are possible explanations for the alerting feature. Practitioners should continue to monitor the alerting features. In health, they may be included in the differential diagnosis.
- to **suspect** child abuse or neglect means a serious level of concern about the possibility of child abuse or neglect but is not proof of it.

Elsewhere in this guideline 'consider' reflects the strength of evidence, in line with developing NICE guidelines: the manual.

Children and young people telling others about abuse and neglect

1.2.1 Recognise that children and young people who are being abused or neglected may find it difficult to tell someone for the first time because:

- they may have feelings of shame, guilt and of being stigmatised
- they may not always recognise their own experiences as abusive
- they may be being coerced by (or may be attached to) their abuser
- they may fear the consequences of telling someone, for example that the abuse might get worse, their family will be split up or they will go into care.

1.2.2 Recognise that children and young people who are experiencing abuse or neglect may not acknowledge this when questioned, or may not want others to know.

1.2.3 Recognise that children and young people may communicate their abuse or neglect indirectly through their behaviour and appearance (see NICE's guideline on child maltreatment and recommendations 1.2.12 to 1.2.455 in this guideline).

1.2.4 Explore your concerns with children and young people in a non-leading way, for example by using open questions, if you are worried that they may be being abused or neglected.

1.2.5 Avoid causing possible prejudice to any formal investigation during early conversations about abuse and neglect with children and young people. Follow guidance in the Ministry of Justice's Achieving best evidence in criminal proceedings.

1.2.6 If a child or young person tells you that they have experienced abuse or neglect, explain to them whom you will need to tell, and discuss what will happen next and when.

Child risk factors for abuse and neglect

1.2.7 For disabled children, be aware that their disability may increase the risk of abuse or neglect by their parents, carers or others, and make it harder to recognise. Also remember that disabled children may have many carers.

1.2.8 Recognise that both girls and boys can be sexually exploited, and that child sexual exploitation is not confined to a particular sexual orientation.

Parental risk factors for abuse and neglect

1.2.9 Consider abuse and neglect if a parent, carer, sibling or other adult in a child's household has 1 or more of the following risk factors:

- They have substance misuse difficulties.
- There is a history of domestic abuse.
- They are emotionally volatile or have problems managing their anger.
- They are experiencing mental health problems.

The risk factors above may be compounded if the parent, carer, sibling or other adult in a child's household lacks support from family or friends.

1.2.10 Recognise the following as risk factors for recurring or persistent child abuse and neglect:

- The parent or carer does not engage with services.
- There have been 1 or more previous episodes of abuse or neglect.
- The parent or carer has a mental health or substance misuse problem.
- There is chronic parental stress.
- The parent or carer experienced abuse or neglect as a child.

Recognise that neglect and emotional abuse are more likely to recur or persist than other forms of abuse.

Practitioner awareness of risk

1.2.11 Recognise that risk factors can be interrelated, and that separate factors can combine to increase the risk of harm to a child or young person.

Indicators of abuse and neglect: child behaviour and emotional states

General behavioural and emotional indicators of child abuse and neglect

1.2.12 Consider current abuse and neglect if a child or young person displays, or is reported to display, either of the following that differs from what would be expected for their age and developmental stage (see boxes 1 and 2):

- a marked change in behaviour or emotional state or
- repeated, extreme or sustained emotional responses.

Consider abuse and neglect even if these initially appear to be explained by a known stressful situation (for example, bereavement or parental separation).*

Box 1 Examples of behaviour and emotional states

- Being fearful or withdrawn, low self-esteem
- Extreme distress
- Wetting and soiling
- Recurrent nightmares containing similar themes
- Aggressive, oppositional behaviour
- Withdrawal of communication
- Lack of ability to understand and recognise emotions
- Habitual body rocking
- Indiscriminate contact or affection seeking
- Over-friendliness to strangers, including healthcare practitioners
- Excessive clinginess
- Persistently seeking attention
- Demonstrating excessively 'good' behaviour to prevent parental or carer disapproval
- Failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed
- Coercive controlling behaviour towards parents or carers
- Very young children showing excessive comforting behaviours when witnessing parental or carer distress.

Box 2 Examples of emotional responses

- Frequent rages at minor provocation
- Distress expressed as inconsolable crying
- Anger or frustration expressed as a temper tantrum in a school-aged child.

1.2.13 Consider past (as well as current) abuse and neglect if a child or young person shows repeated, extreme or sustained emotional responses as described in 1.2.12.

1.2.14 Consider current or past abuse and neglect if a child shows dissociation (transient episodes of detachment that are outside the child's control and that are distinguished from daydreaming, seizures or deliberate avoidance of interaction).*

1.2.15 Consider current or past abuse or neglect if children or young people are showing any of the following behaviours:

- substance or alcohol misuse
- self-harm
- eating disorders
- suicidal behaviours
- bullying or being bullied.

1.2.16 Consider current or past abuse and neglect if a child or young person has run away from home or care.*

1.2.17 Consider current or past abuse and neglect if a child or young person is living in alternative accommodation without the justified agreement of their parents or carers.*

1.2.18 Consider abuse and neglect if a child or young person regularly has responsibilities that interfere with the child's essential normal daily activities (for example, school attendance).*

1.2.19 Consider current or past abuse and neglect if a child responds to a health examination or assessment in an unusual, unexpected or developmentally inappropriate way (for example, extreme passivity, resistance or refusal).*

Sexual behavioural indicators of child abuse and neglect

For more guidance about responding to potentially harmful sexual behaviours, see NICE's guideline on harmful sexual behaviour among children and young people.

1.2.20 Suspect current or past abuse and neglect if a child or young person's sexual behaviour is indiscriminate, precocious or coercive.*

1.2.21 Suspect abuse and neglect, and in particular sexual abuse, if a pre-pubertal child displays or is reported to display repeated or coercive sexualised behaviours or preoccupation (for example, sexual talk associated with knowledge, emulating sexual activity with another child).*

1.2.22 Suspect sexual abuse if a pre-pubertal child displays or is reported to display unusual sexualised behaviours. Examples include:

- oral–genital contact with another child or a doll
- requesting to be touched in the genital area
- inserting or attempting to insert an object, finger or penis into another child's vagina or anus.*

Behavioural indicators of child neglect

1.2.23 Suspect current or past abuse and neglect if a child repeatedly scavenges, steals, hoards or hides food with no medical explanation (for example Prader–Willi syndrome).*

1.2.24 Suspect neglect if you repeatedly observe or hear reports of any of the following in the home that is in the parents or carers' control:

- a poor standard of hygiene that affects a child's health
- inadequate provision of food
- a living environment that is unsafe for the child's developmental stage.

Be aware that it may be difficult to distinguish between neglect and material poverty. However, care should be taken to balance recognition of the constraints on the parents or carers' ability to meet their children's needs for food, clothing and shelter with an appreciation of how people in similar circumstances have been able to meet those needs.*

1.2.25 Suspect neglect if a child is persistently smelly and dirty. Take into account that children often become dirty and smelly during the course of the day. Use judgement to determine if persistent lack of provision or care is a possibility. Examples include:

- child seen at times of the day when it is unlikely that they would have had an opportunity to become dirty or smelly (for example, an early morning visit)
- if the dirtiness is ingrained.*

1.2.26 Consider neglect if a child has severe and persistent infestations, such as scabies or head lice.*

1.2.27 Consider neglect if a child's clothing or footwear is consistently inappropriate (for example, for the weather or the child's size). Take into account that instances of inadequate clothing that have a suitable explanation (for example, a sudden change in the weather, slippers worn because they were closest to hand when leaving the house in a rush) would not be alerting features for possible neglect.*

Indicators of abuse and neglect: child development

1.2.28 Consider neglect if a child displays faltering growth because of lack of provision of an adequate or appropriate diet.*

1.2.29 Consider physical or emotional abuse or neglect if a child under 12 shows poorer than expected language abilities for their overall development (particularly in their ability to express their thoughts, wants and needs) that is not explained by other factors, for example speaking English as a second language.

Indicators of abuse and neglect: interactions between children and young people and parents or carers

These recommendations assume that practitioners are seeing a parent or carer and child interacting.

1.2.30 Consider neglect or physical abuse if a child's behaviour towards their parent or carer shows any of the following, particularly if they are not observed in the child's other interactions:

- dislike or lack of cooperation
- lack of interest or low responsiveness
- high levels of anger or annoyance
- seeming passive or withdrawn.

1.2.31 Consider emotional abuse if there is concern that parent– or carer–child interactions may be harmful. Examples include:

- Negativity or hostility towards a child or young person.
- Rejection or scapegoating of a child or young person.
- Developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining.
- Exposure to frightening or traumatic experiences, including domestic abuse.
- Using the child for the fulfilment of the adult's needs (for example, in marital disputes).
- Failure to promote the child's appropriate socialisation (for example, involving children in unlawful activities, isolation, not providing stimulation or education).*

1.2.32 Suspect emotional abuse if the interactions observed in recommendation 1.2.31 are persistent.*

1.2.33 Consider emotional neglect if there is emotional unavailability and unresponsiveness from the parent or carer towards a child or young person and in particular towards an infant.*

1.2.34 Suspect emotional neglect if the interaction observed in recommendation 1.2.333 is persistent.*

1.2.35 Consider abuse and neglect if parents or carers are seen or reported to punish a child for wetting and soiling despite practitioner advice that the symptom is involuntary.*

1.2.36 Consider abuse and neglect if a parent or carer refuses to allow a child or young person to speak to a practitioner on their own when it is necessary for the assessment of the child or young person.*

1.2.37 Recognise that excessive physical punishment constitutes physical abuse.

Supervision by parents and carers

1.2.38 Suspect neglect if parents or carers persistently fail to anticipate dangers and to take precautions to protect their child from harm. However, take into account that achieving a balance between an awareness of risk and allowing children freedom to learn by experience can be difficult.*

1.2.39 Consider neglect if the explanation for an injury (for example, a burn, sunburn or an ingestion of a harmful substance) suggests a lack of appropriate supervision.*

1.2.40 Consider neglect if a child or young person is not being cared for by a person who is able to provide adequate care.*

Providing access to medical care or treatment

1.2.41 Consider neglect if parents or carers fail to collect or administer essential prescribed treatment for their child.*

1.2.42 Consider neglect if parents or carers repeatedly fail to attend follow-up appointments that are essential for their child's health and wellbeing.*

1.2.43 Consider neglect if parents or carers persistently fail to engage with relevant child health promotion programmes, which include:

- immunisation
- health and development reviews
- screening.*

1.2.44 Consider neglect if parents or carers have access to but persistently fail to obtain NHS treatment for their child's dental caries (tooth decay).*

1.2.45 Suspect neglect if parents or carers fail to seek medical advice for their child to the extent that the child's health and wellbeing is compromised, including if the child is in ongoing pain.*

Supporting practitioners to recognise abuse and neglect

1.2.46 Ensure all practitioners working in primary care can recognise and respond to child abuse and neglect. Ways to achieve this include:

- training newly qualified doctors in risk factors for abuse and neglect, such as parental mental health problems, alcohol and substance misuse (and providing top-up training sessions every 6 months)
- giving information to newly qualified practitioners, for example about local resources such as children's centres and parenting groups
- completing a standardised questionnaire to screen for risk factors
- providing access to a social worker if possible.

1.2.47 Ensure practitioners working in community settings, including education, can recognise and respond to child abuse and neglect and are aware of child safeguarding guidance relevant to their profession, for example the Department for Education's Keeping children safe in education.

Recognising child trafficking

1.2.48 Recognise that there are many reasons why children and young people may be trafficked other than for sexual exploitation. Other forms of exploitation include:

- forced marriage
- domestic servitude
- working for low or no pay, or in illegal industries
- being used for benefit fraud.

1.2.49 Recognise that both girls and boys can be trafficked and that children and young people from the UK can be trafficked, as well as those from other countries.

1.2.50 If you suspect a child or young person may have been trafficked:

- ensure that concerns about their age and immigration status do not override child protection considerations
- recognise that choosing an interpreter from the child's community may represent to them the community that has exploited them
- aim to ensure continuity with the same interpreter, keyworker or independent advocate.

1.3 Assessing risk and need in relation to abuse and neglect

This section refers to assessment of risk and need in relation to child abuse and neglect, including early help assessment, and assessment under Section 17 and enquiry under Section 47 of the Children Act 1989. Local authority social workers have a statutory duty to lead assessments under the Children Act 1989. The police, teachers and other relevant processionals should provide information as part of this process.

Carrying out assessments

1.3.1 Practitioners leading the assessment should ensure that all significant adults, children and young people in the family are involved. This means:

- finding out their views and wishes
- taking time to understand family relationships and dynamics.

Exceptions are adults who could affect the nature of a criminal investigation, for example in cases of sexual abuse, induced illness, serious physical abuse or neglect and forced marriage.

1.3.2 As part of the assessment, collect and analyse information about all significant people in the child’s care environment. The assessment should include each person’s:

- family, personal, social and health history, and
- experiences of being parented.

1.3.3 When assessing a child or young person for abuse and neglect:

- observe the child or young person
- communicate directly with them
- explore in a non-leading way any presenting signs of child abuse and neglect.

Do not rely solely on information from the parent or carer in an assessment. See also recommendations 1.1.1 to 1.1.12 about working with children, young people, parents and carers.

1.3.4 When assessing a child or young person follow the principles in recommendation 1.1.3 and also:

- keep them involved and informed at every stage of assessment and decision-making
- tailor communication to their specific needs (see recommendation 1.1.2)
- reinforce that they have a right to talk about any abuse or neglect and to seek help.

1.3.5 Provide training in communication skills to enable practitioners assessing children and young people to identify and interpret signs of abuse and neglect.

1.3.6 Practitioners should adopt an individualised approach to assessment that takes into account each child or young person's specific needs.

1.3.7 Communicate concerns honestly to families about child abuse and neglect, taking into account confidentiality. Think about what information should be shared, and with whom, to avoiding placing the child at risk of further harm.

1.3.8 During assessment, focus primarily on the child's needs but also remember to:

- address both the strengths and weaknesses of parents and carers and acknowledge that parenting can change over time
- focus attention equally on male and female parents and carers.

Developing a plan

1.3.9 Analyse the information collected during assessment and use it to develop a plan describing what services and support will be provided. This should be agreed with the child and their family (also see recommendation 1.1.7). Analysis should include evaluating the impact of any risk factors.

Supporting practitioners to undertake good quality assessment

1.3.10 Organisations should ensure that practitioners conducting assessment in relation to abuse or neglect of disabled children or young people can access a specialist with knowledge about those children and young people's specific needs and impairments.

1.4 Early help for families showing possible signs of abuse or neglect

Home visiting programmes

1.4.1 Consider a programme of home visits, lasting at least 6 months, for parents or carers at risk of abusing or neglecting their child or children. This includes parents or carers with previously confirmed instances of abuse and neglect.

1.4.2 Identify parents and carers who would benefit from a programme of home visits during pregnancy or shortly after birth, wherever possible.

1.4.3 Ensure that the programme of home visits includes:

- support to develop positive parent–child relationships, including:
  - helping parents to understand children's behaviour more positively
  - modelling positive parenting behaviours

  - observing and giving feedback on parent–child interactions
- helping parents to develop problem-solving skills
- support for parents with substance misuse and mental health difficulties
- support for parents to access relevant services, including healthcare, early years, educational services and other community services.

1.4.4 Ensure that the programme of home visits is delivered by either a health or social care practitioner or another worker who has been trained in delivering that particular home visiting programme.

Parenting programmes

1.4.5 Consider a parenting programme for parents or carers at risk of abusing or neglecting their child or children. Tailor parenting programmes to the specific needs of the family (see recommendations 1.4.7 to 1.4.10).

1.4.6 When selecting parenting programmes think about whether parents or carers would benefit from help to:

- develop skills in positive behaviour management
- address negative beliefs about the child and their own parenting
- manage difficult emotions, including anger.

1.4.7 Consider the Enhanced Triple P (attributional retraining and anger management) programme for mothers of children aged 2 to 7, who are experiencing anger management difficulties.

1.4.8 Consider the Parents Under Pressure programme for mothers taking part in methadone maintenance programmes.

1.4.9 Consider a planned activities training programme, with or without mobile phone support, for vulnerable mothers (for example, those with a low level of education or income or aged under 18) of preschool children.

1.4.10 For parents or carers who have substance misuse problems, include content in the parenting programme to help them address their substance misuse in the context of parenting.

Supporting families

1.4.11 Offer support to families as part of building helpful working relationships with them. This could include:

- practical support, for example help to attend appointments and details of other agencies that can provide food, clothes and toys
- emotional support, including empathy and active listening, and help to develop strategies for coping.

1.4.12 Give families information about local services and resources that they may find useful.

Knowledge and skills of practitioners who provide early help

1.4.13 Ensure that all practitioners working at the early help stage:

- understand the parental risk factors for child abuse and neglect (see recommendations 1.2.9 to 1.2.10)
- are aware of the possibility of escalation of risk, particularly if family circumstances change.

1.4.14 Ensure that practitioners understand how to work with families as a whole in order to better support children and young people.

1.5 Response and support following abuse and neglect

1.5.1 After making a child protection referral:

- do not relinquish responsibility for the referral
- follow up the referral
- ensure action takes place.

You should expect to hear back from children's social care whether or not action has been taken, and the timescale of this action. If there is no action, follow local escalation policies if needed.

1.5.2 Practitioners working with families in which a child is involved in statutory child protection processes should:

- take part in case conferences and meetings about the child
- have an initial meeting with relevant practitioners to agree roles, responsibilities and ways of working, and to share information
- build relationships with other practitioners working with that family
- make sure all stakeholders can keep in touch with each other about the child
- organise handovers if new staff members become involved
- ensure actions are completed.

Support for children and young people after abuse and neglect

1.5.3 Ensure that all children and young people who have been abused or neglected are given a minimum of:

- a safe place to live
- an opportunity to be actively listened to and believed
- support to explore aspects of their experience and express their feelings
- early emotional support, including building emotional resilience and strategies for coping with symptoms such as nightmares, flashbacks and self-harm
- support to reduce the risk of further abuse if appropriate, for example if a young person is at risk of sexual exploitation.

Children affected by domestic abuse

1.5.4 Ensure that police officers responding to incidents of domestic abuse have the confidence and skill to communicate with children and young people when needed, and information on how to make a referral.

Child trafficking

1.5.5 When working with children and young people who have been trafficked, provide:

- safe accommodation
- legal support
- specialist and trained interpreters if needed

- culturally appropriate mental health services.

1.6 Therapeutic interventions for children, young people and families after abuse and neglect

1.6.1 Discuss in detail with children, young people and their families any interventions you offer them, explaining what the intervention will involve and how you think it may help.

1.6.2 Give children, young people and their families a choice of proposed interventions if possible. Recognise that some interventions, although effective, may not suit that person or family.

1.6.3 Take into account the age and developmental stage of the child or young person when selecting interventions.

Therapeutic interventions following physical abuse, emotional abuse or neglect

This section provides a range of options for therapeutic interventions for children and young people who have been abused or neglected. Some interventions involve the parents or carers who abused or neglected the child, and others involve alternative carers such as foster carers or adoptive parents.

Children under 5 and their parents or carers

1.6.4 Offer an attachment-based intervention to parents or carers who have neglected or physically abused a child under 5.

1.6.5 Deliver the attachment-based intervention in the parent or carer's home and aim to:

- improve how they nurture their child, including when the child is distressed
- improve their understanding of what their child's behaviour means
- help them respond positively to cues and expressions of the child's feelings
- improve how they manage their feelings when caring for their child.

1.6.6 Consider child–parent psychotherapy for parents or carers and children under 5 if the parent or carer has physically or emotionally abused or neglected the child, or the child has been exposed to domestic violence.

1.6.7 Ensure that child–parent psychotherapy:

- is based on the Cicchetti and Toth model[1]
- consists of weekly sessions (lasting 45–60 minutes) over 1 year
- is delivered in the parents' home, if possible, by a therapist trained in the intervention
- involves directly observing the child and the parent–child interaction
- explores the parents' understanding of the child's behaviour
- explores the relationship between the emotional reactions of the parents and their perceptions of the child on the one hand, and the parents' own childhood experiences on the other hand.

[This recommendation is adapted from NICE's guideline on children's attachment.]

Children under 12 and their parents or carers

1.6.8 Consider a comprehensive parenting intervention for parents and children under 12 if the parent or carer has physically or emotionally abused or neglected the child. This should comprise weekly home visits for at least 6 months that address:

- parent–child interactions
- caregiving structures and parenting routines
- parental stress
- home safety
- any other issues that caused the family to come to the attention of services.

[1] Cicchetti D, Rogosch FA, Toth SL (2006) Fostering secure attachment in infants in maltreating families through preventive interventions. Development and Psychopathology 18: 623–49
Toth SL, Maughan A, Manly JT et al. (2002) The relative efficacy of two interventions in altering maltreated preschool children's representational models: implications for attachment theory. Development and Psychopathology 14: 877–908

As part of the intervention, help the family to access other services they might find useful.

1.6.9 Consider parent–child interaction therapy for parents and children under 12 if the parent has physically abused or neglected the child. Combine group sessions for these parents with individual child–parent sessions focusing on developing child-centred interaction and effective discipline skills.

Children and young people over 10 and their parents or carers

1.6.10 Consider multi-systemic therapy for child abuse and neglect (MST-CAN) for parents, children and young people aged 10 to 17 if the parent has abused or neglected their child. This should:

- involve the whole family
- address multiple factors contributing to the problem
- be delivered in the home or in another convenient location
- include a round-the-clock on-call service to support families to manage crises.

Foster carers and those providing permanence for children under 5

1.6.11 Offer an attachment-based intervention in the home to foster carers looking after children under 5 who have experienced abuse or neglect. Aim to help foster carers to:

- improve how they nurture their foster child, including when the child is distressed
- improve their understanding of what the child's behaviour means
- respond positively to cues and expressions of the child's feelings
- behave in ways that are not frightening to the child
- improve how they manage their feelings when caring for their child.

[This recommendation is adapted from NICE's guideline on children's attachment.]

1.6.12 Consider the attachment-based intervention in recommendation 1.6.11 for adoptive parents and those providing permanence (including special guardians, foster carers or kinship carers) for children under 5 who have experienced abuse or neglect.

Foster carers and those providing permanence for children and young people aged 5 to 17

1.6.13 For foster carers of children aged 5 to 12 who have experienced abuse and neglect, consider a group-based parent training intervention that includes strategies to manage behaviour and discipline positively. This should include using video, roleplay and homework practice.

1.6.14 For foster carers, adoptive parents and those providing permanence for children and young people aged 5 to 17 who have experienced abuse or neglect, consider a trauma-informed group parenting intervention, using a trust-based relational intervention as an example. It should help to:

- develop the child's capacity for self-regulation
- build trusting relationships
- develop proactive and reactive strategies for managing behaviour.

Therapeutic interventions for children, young people and families after sexual abuse

1.6.15 Consider group or individual trauma-focused cognitive behavioural therapy for children and young people (boys and girls) who have been sexually abused and show symptoms of anxiety, sexualised behaviour or post-traumatic stress disorder. When offering this therapy:

- discuss it fully with the child or young person before providing it, in light of the fact that some children and young people do not find this intervention helpful
- make clear that there are other options available if they would prefer
- provide separate sessions for the non-abusing parent or carer.

1.6.16 For children and young people (boys and girls) aged 8 to 17 who have been sexually abused, consider a programme, for example 'Letting the future in', that:

- emphasises the importance of the therapeutic relationship between the child and therapist
- offers support tailored to the child's needs, drawing on a range of approaches including counselling, socio-educative and creative approaches (such as drama or art)
- includes individual work with the child (up to 20 sessions, extending to 30 as needed) and parallel work with non-abusing parents or carers (up to 8 sessions).

1.6.17 For girls aged 6 to 14 who have been sexually abused and who are showing symptoms of emotional or behavioural disturbance, consider one of the following, after assessing carefully and discussing with the girl which option would suit her best:

- individual focused psychoanalytic therapy (up to 30 sessions) **or**
- group psychotherapeutic and psychoeducational sessions (up to 18 sessions).

Provide separate sessions for the non-abusing parent or carer.

1.7 Planning and delivering services

1.7.1 Plan services in a way that enables children, young people, parents and carers to work with the same professionals over time where possible.

1.7.2 For cases involving children not already subject to protection plans, agencies responsible for planning and delivering statutory child protection services should agree common terminology to describe multi-agency working arrangements, including:

- the terms used to describe meetings
- defining who the lead practitioner is.

1.7.3 Agencies responsible for planning and delivering services for children should agree clear joint protocols for addressing abuse and neglect at the early help stage, and through statutory child protection processes. Ensure these:

- address less well-recognised forms of abuse, including child sexual exploitation, female genital mutilation, forced marriage and child trafficking, serious youth violence and gang membership
- are communicated to all agencies, including those providing universal services.

1.7.4 Agencies must address obstacles to partnership working, including agreeing ways to support sharing information when it is in a child or young person's best interests, in line with statutory guidance given in Working together to safeguard children. (For additional advice on this see the Department for Education's Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers.) For example, allow agreed database access to staff from other agencies, or integrate teams from different agencies.

1.7.5 Ensure staff from different agencies who are working on the same, or related, cases or issues are co-located wherever possible.

1.7.6 To address the risks posed by sexual exploitation and gangs, agencies responsible for planning and delivering services for children and young people should ensure there is:

- effective leadership within agencies
- a local lead who will coordinate planning and information sharing between agencies.

Supervision and support for staff

1.7.7 For staff working in child protection from different agencies, particularly those who are co-located, provide ongoing opportunities to:

- maintain their professional skills and competencies

- stay in touch with colleagues from their own professional discipline.

1.7.8 Organisations should support staff working with children and families at risk of or experiencing abuse, and ensure they have access to good quality supervision. This should include:

- case management
- reflective practice
- emotional support
- continuing professional development.

2 Research recommendations

The guideline committee has made the following recommendations for research.

2.1 Recognition of sexual abuse

Research question

What approaches to practice enable children (both boys and girls) who have been sexually abused to begin to tell practitioners about their experiences earlier, and in a way that does not contaminate the reliability of subsequent court proceedings?

Why this is important

Research shows that many children and young people who are sexually abused do not tell anyone about their abuse. Among those who do, many delay telling someone for a long time, sometimes until adulthood. We found little research identifying the approaches or techniques that would make it more likely for a child being sexually abused to tell a practitioner about it. Although there is an evidence base on Achieving Best Evidence interviewing as part of a formal investigation, there is less evidence about approaches that can be used at an earlier stage. Studies are needed that would identify effective approaches to enable children to talk about sexual abuse, while ensuring that these early conversations do not contaminate evidence at a later stage in an investigation.

Criterion	Explanation
Population	Children and young people (under 18) who have been sexually abused. Adults who were sexually abused in childhood. Practitioners working with children and young people who have been sexually abused.
Intervention	Conversational techniques and approaches which enable children and young people who are experiencing abuse to tell someone about the abuse.
Comparators	Current standard practice, alternative techniques and approaches.
Outcomes	Improved recognition of sexual abuse. Improvements to children and young people's wellbeing.
Study design	Study designs could include Randomised Controlled Trial (RCTs) of specific interventions, or other types of evaluation to ascertain whether particular approaches improve rates of recognition. It will also be important to gain children, young people and practitioners' feedback as part of any studies.
Timeframe	No specific comments.

2.2 Recognition of risk and prevention of female genital mutilation

Research question

What interventions are effective and cost effective in:

- Improving practitioners' recognition of children who are at risk of female genital mutilation (FGM) in the UK or overseas?
- improving recognition of co-occurring forms of abuse where relevant?
- preventing FGM in this group?

Why this is important

There is a lack of evidence from the UK about how practitioners can be supported to recognise girls and young women who are at risk of FGM and effective interventions to prevent FGM. This is despite evidence that many practitioners are likely to encounter young women at risk of FGM. There is also a lack of evidence about the extent to which FGM is a risk factor or indicator of other forms of abuse, and therefore whether identification of FGM should be accompanied by other types of assessment and support. The Home Office has developed an FGM recognition and prevention e-learning resource; however the effectiveness of this resource does not appear to have been evaluated.

Criterion	Explanation
Population	Girls and young women aged under who are normally resident in the UK who are at risk of experiencing in the UK or overseas.
Intervention	Interventions to: • improve recognition by professionals of children who are at risk of experiencing female genital mutilation (FGM) in the UK or overseas • improve recognition of co-occurring forms of abuse where relevant • prevent FGM in this group This may include training and awareness raising for professionals.
Comparators	No intervention, practice as usual.
Outcomes	Improved knowledge and understanding of FGM among practitioners. Improved rate of identification of FGM among practitioners. Reduced rates of FGM.
Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions or other types of evaluation with the purpose of ascertaining what interventions are effective in supporting recognition and thereby improving prevention. It will also be important to gain children, young people and practitioners' feedback as part of any studies.
Timeframe	No specific comments.

2.3 Recognition of risk and prevention of 'honour-based' violence and forced marriage

Research question

What interventions are effective and cost effective in:

- improving practitioners' recognition of children who are at risk of or experiencing 'honour-based' violence and forced marriage?
- preventing 'honour-based' violence and forced marriage?

Why this is important

There is a lack of evidence from the UK about how practitioners can be supported to recognise children and young people who are at risk of or experiencing 'honour-based' violence, and how to prevent it. There is also little evidence showing which interventions are most effective for recognising young people at risk of forced marriage and for preventing such marriages from taking place. The government's The right to choose: multi-agency statutory guidance for dealing with forced marriage explains the issues around forced marriage, provides a clear definition and

distinction from arranged marriage, lists some of the potential warning signs or indicators, and recommends organisational approaches to dealing with forced marriage. However, the effectiveness of these approaches has not been evaluated.

Criterion	Explanation
Population	Children and young people under 18 or are at risk of or experiencing so-called honour-based violence or forced marriage
Intervention	Interventions to: • improve recognition of honour-based violence and forced marriage • prevent honour-based violence and forced marriage. This may include training and awareness raising for professionals.
Comparators	No intervention.
Outcomes	Improved knowledge and understanding of honour-based violence among practitioners. Improved rate of identification of honour-based violence by practitioners. Reduced rates of honour-based violence.
Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions or other types of evaluation with the purpose of ascertaining what interventions are effective in supporting recognition and thereby improving prevention. It will also be important to gain children, young people and practitioners' feedback as part of any studies.
Timeframe	No specific comments.

2.4 Statutory reporting systems for abuse and neglect

Research question

How could the current UK statutory reporting system for child abuse and neglect be strengthened?

Why this is important

The evidence we reviewed suggested that a significant proportion of abuse and neglect remains undetected. Measures to improve detection rates, such as mandatory reporting, have been considered but not yet implemented in the UK. Consideration of the current barriers to recognising and reporting abuse and neglect would help to inform measures for improving detection.

Criterion	Explanation
Population	Practitioners working with children and young people.

Intervention	Measures to improve recognition of abuse and neglect, and reporting according to statutory guidelines, for example mandatory reporting.
Comparators	Practice as usual
Outcomes	Improved reporting rate of abuse and neglect.
Study design	Study designs could include pilot studies implementing measures such as mandatory reporting in a sample of areas, and comparison of rates or reporting with areas without additional measures. It will also be important to gain practitioners' feedback as part of any studies.
Timeframe	No specific comments.

2.5 Early help home visiting

Research question

What are the components of effective home visiting programmes for preventing child abuse and neglect in families of children and young people at risk of abuse and neglect in the UK?

Why this is important

There are numerous studies, based mostly in the US, involving home visiting programmes for families at risk of abuse and neglect. The findings of these studies are mixed, with some programmes proving effective but not others. The descriptions of the programmes and their theoretical basis are often poorly reported. It is therefore difficult to ascertain the key ‘active ingredients’ in a successful home visiting programme. A meta-analytic study seeking to obtain additional information from study authors on the features of home visiting programmes and their effectiveness, for example using statistical modelling, would help in understanding these programmes.

Criterion	**Explanation**
Population	Children, young people who are at risk of abuse and neglect and their parents and carers.
Intervention	Home visiting (range of programmes)
Comparators	No intervention/waitlist Other preventative intervention
Outcomes	Reduced incidence of abuse and/or neglect Reduced risk of abuse and/or neglect Improved wellbeing of children and young people Improved wellbeing of parents/carers

Study design	A study examining the association between elements of home visiting interventions and their effectiveness. For this to be robust, it is likely that study authors would need to be contacted for additional information about interventions, or detailed analyses of intervention manuals conducted. Regression analysis could then be conducted to examine association between intervention features and effectiveness.
Timeframe	No specific comments.

2.6 Effective prevention of abuse and neglect in the UK

Research question

What interventions are effective and cost effective in the UK to prevent abuse and neglect of children and young people in families at risk of, or showing early signs of, abuse and neglect?

Why this is important

The evidence reviewed for this guideline on the effectiveness of interventions to prevent abuse and neglect of children and young people was predominantly from outside the UK, and focused on home visiting programmes and parenting programmes. High-quality studies (ideally randomised controlled trials) are needed which:

- look specifically at the effectiveness of interventions to prevent abuse and neglect in the UK
- focus on interventions already being provided in the UK that may have no or low-quality evidence to support them at present.

Criterion	Explanation
Population	Children and young people at risk of abuse and/or neglect and their parents or carers.
Intervention	Interventions to prevent abuse and/or neglect. This could include UK-specific home visiting or parenting programmes and family support interventions which are already being provided, but do not currently have an evidence base.
Comparators	No intervention/waitlist.
Outcomes	Reduced incidence of abuse and/or neglect Reduced risk of abuse and/or neglect Wellbeing of children and young people Wellbeing of parents/carers

Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions or other types of evaluation with the purpose of ascertaining what interventions are effective in preventing abuse or neglect, specifically within a UK context. It will also be important to gain children, young people, parents/carers and practitioners' feedback as part of any studies.
Timeframe	Studies would require sufficient follow up time to capture impacts on wellbeing and incidence of abuse or neglect.

2.7 Reducing social isolation and associated child abuse and neglect

Research question

What is the impact of social isolation on children, young people and families at risk of abuse and neglect in the UK? What interventions are effective and cost effective in a UK context in reducing social isolation and any associated child abuse and neglect?

Why this is important

Evidence presented in How safe are our children? suggests a link between social isolation and child abuse and neglect. However, there is a lack of evidence about what interventions are effective in reducing social isolation and any associated child abuse and neglect. The aim of research should be to inform practitioners and policy-makers of the impact of social isolation, and the methods that lead to successful engagement with socially isolated children, young people and families, and reduction of associated child abuse and neglect.

Criterion	**Explanation**
Population	Socially isolated children, young people, parents and carers at risk of child abuse and neglect
Intervention	Interventions aiming to reduce social isolation and associated abuse and neglect
Comparators	No intervention/waitlist
Outcomes	Reduced social isolation Reduced incidence of abuse and/or neglect Reduced risk of abuse and/or neglect Improved wellbeing of children and young people Improved wellbeing of parents/carers
Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions or other types of evaluation with the purpose of

	ascertaining what interventions are effective in reducing social isolation, abuse and neglect. Statistical analysis of mediation effects will be required to ascertain whether reduction of isolation has a causal impact on reduction of risk and incidence of abuse and neglect. It will also be important to gain children, young people, parents/carers and practitioners' feedback as part of any studies.
Timeframe	Studies would require sufficient follow up time to capture impacts on wellbeing and incidence of abuse or neglect.

2.8 Effective interventions for young people who have been abused or neglected

Research question

What interventions are effective and cost effective in improving the wellbeing of young people aged 12 to 17 who have experienced abuse or neglect, including those who are now in temporary or permanent alternative care placements?

Why this is important

There is little evidence on effective interventions to improve the wellbeing of older children and young people who have experienced abuse and neglect, except for those who have been sexually abused. Studies are needed that evaluate interventions for young people aged 12 and over who have been abused or neglected in the past, but are now in temporary or permanent alternative care placements. These include foster care, kinship care, residential care, special guardianship and adoption.

Criterion	Explanation
Population	Children and young people aged 12 and over who have experienced abuse or neglect, including those who are now in temporary or permanent alternative care placements, including (but not limited to) foster care, kinship care, residential care, special guardianship or adoption.
Intervention	Interventions to improve wellbeing following experience of abuse or neglect. This may include individual therapeutic interventions, but could also include other types of interventions provided to a child or young person with the aim of improving wellbeing. It could also include interventions provided to carers.
Comparators	Care as usual, waitlist
Outcomes	Improved wellbeing of children and young people Improved carer/child relationships Improved wellbeing of carers

Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions, or other types of evaluation with the aim of ascertaining what interventions are effective in improving the wellbeing of older children and young people who have been abused or neglected in the past. It will also be important to gain children, young people, carers' and practitioners' feedback as part of any studies.
Timeframe	Study would require sufficient follow up time to capture impacts on wellbeing.

2.9 Effective interventions for addressing abuse and neglect in the UK

Research question

What interventions, approaches and methodologies provided by social care and voluntary sector services are effective and cost effective in the UK to prevent the recurrence of abuse and neglect, and to improve the wellbeing of children, young people and families?

Why this is important

The evidence reviewed for this guideline on the effectiveness of interventions to address abuse and neglect of children and young people was predominantly from outside the UK. We identified interventions, approaches and methodologies being used in the UK but many of these could not be included because they have not been evaluated using high-quality research designs. High-quality studies are needed to show policy-makers and practitioners which ones are effective in the UK and in what circumstances.

Criterion	**Explanation**
Population	Children and young people who are experiencing or have experienced abuse and neglect and their parents or family carers.
Intervention	Interventions for the above population currently in common use in the UK. This may include individual therapeutic interventions, but could also include other types of interventions provided to a child or young person with the aim of improving wellbeing.
Comparators	Waitlist or other type of intervention.
Outcomes	Reduced incidence of abuse and/or neglect Reduced risk of abuse and/or neglect Improved parent-child relationships Improved wellbeing of children and young people

	Improved wellbeing of parents/carers
Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions, or other types of evaluation with the aim of ascertaining what interventions are effective in improving the wellbeing of children and young people who have been abused or neglected. It will also be important to gain children, young people, parents/carers and practitioners' feedback as part of any studies.
Timeframe	Studies would require sufficient follow-up time to capture impacts on wellbeing and incidence of abuse or neglect.

2.10 Interventions with fathers and male carers

Research question

What interventions are effective and cost effective when working with fathers and male carers to improve their parenting in families where children are being, or have been, abused or neglected?

Why this is important

There is a lack of research evidence from the UK showing what interventions are effective to improve fathers' and male carers' parenting in families where children are being, or have been, abused or neglected. Most studies reviewed for this guideline, both from the UK and elsewhere, focused on female carers. Studies are needed to show what interventions and practices are effective in engaging fathers and male carers, and improving their parenting if needed.

Criterion	Explanation
Population	Families where children are being or have been abused or neglected where the fathers or male carers are present.
Intervention	Interventions to improve the father or male carer's parenting
Comparators	No intervention/waitlist where appropriate, or another intervention.
Outcomes	Reduced incidence of abuse and/or neglect Reduced risk of abuse and/or neglect Improved parent-child relationships Wellbeing of children and young people Wellbeing of parents/carers
Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions, or other types of evaluation with the aim of ascertaining what interventions are effective in engaging fathers and male carers and supporting them to improve parenting. It will also be important

	to gain children, young people, parents/carers and practitioners' feedback as part of any studies.
Timeframe	Studies would require sufficient follow-up time to capture impacts on wellbeing and incidence of abuse or neglect.

2.11 Interventions with male foster carers and adoptive parents

Research question

What interventions are effective and cost effective when working with male foster carers and adoptive parents who are caring for children and young people who have been abused in the past?

Why this is important

There is a lack of research evidence from the UK on what interventions are effective in working with male foster carers and adoptive parents – much of the existing literature is in relation to female foster carers and adoptive parents.

Criterion	Explanation
Population	Male foster carers and adoptive parents caring for children and young people who have been abused in the past.
Intervention	Interventions to improve parenting
Comparators	No intervention/waitlist where appropriate, or another intervention.
Outcomes	Reduced incidence of abuse and/or neglect Reduced risk of abuse and/or neglect Improved parent-child relationships Wellbeing of children and young people Wellbeing of parents/carers
Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions, or other types of evaluation with the aim of ascertaining what interventions are effective in engaging and supporting male foster carers and adoptive parents. It will also be important to gain children, young people, carers' and practitioners' feedback as part of any studies.
Timeframe	Studies would require sufficient follow-up time to capture impacts on wellbeing and incidence of abuse or neglect.

2.12 Effectiveness of home visiting following abuse or neglect

Research question

Are home visiting interventions effective and cost effective in improving parenting and preventing recurrence of abuse and neglect in families in which abuse or neglect is occurring or has occurred?

Why this is important

There is a lack of evidence from the UK on the impact of home visiting on families in which abuse or neglect is occurring or has occurred (as opposed to its impact on prevention). For children who are subject to a child protection plan, home visiting is one of the tools that may be used for monitoring their welfare and their interaction with their parents or carers. It is also used for engaging with parents or carers to address abusive or neglectful behaviours or ensure children are protected. There is a need for studies which identify what practices are effective in ensuring the safety and wellbeing of children and young people.

Criterion	**Explanation**
Population	Families where abuse or neglect has occurred or is occurring
Intervention	Home visiting
Comparators	Waitlist where appropriate, or another intervention.
Outcomes	Reduced incidence of abuse and/or neglect Reduced risk of abuse and/or neglect Improved parent-child relationships Improved wellbeing of children and young people Improved wellbeing of parents/carers
Study design	Study designs could include evaluation examining specific practices employed as part of home visiting when working with families where abuse or neglect has occurred. This would acknowledge the fact that home visiting is commonly carried out with these families, but little is known about what practices within this setting help families to change and address problematic behaviours. It will be important to gain children, young people, parent/carers and practitioners' feedback as part of any studies.
Timeframe	Studies would require sufficient follow-up time to capture impacts on wellbeing and incidence of abuse or neglect.

2.13 Effective interventions for parents or carers with substance misuse problems

Research question

What interventions, including family behaviour therapy, are effective and cost effective in improving parenting and preventing recurrence of neglect by parents or carers with substance misuse problems and whose children are on a child protection plan under the category of neglect in the UK?

Why this is important

There is a lack of evidence from the UK about the impact of family behaviour therapy and other interventions on parents and carers with substance misuse problems who show neglectful parenting. A study could show the effectiveness of family behaviour and other interventions, and the timescales for delivering such interventions. In some cases, it may take longer than the 26-week timescale of care proceedings to address parents' substance misuse problems. This research could inform court decisions about whether to extend the time limit if there was a realistic possibility of reunification at the end of the intervention.

Criterion	Explanation
Population	Families where mothers, fathers or carers have substance misuse problems and children are under a child protection plan under the category of neglect.
Intervention	Family behaviour therapy; other identified interventions
Comparators	No intervention/waitlist.
Outcomes	Reduced incidence of abuse and/or neglect Reduced risk of abuse and/or neglect Improved wellbeing of children and young people Improved wellbeing of parents/carers
Study design	D
Timeframe	Studies would require sufficient follow-up time to capture impacts on wellbeing and incidence of abuse or neglect. The study should also investigate the time taken for change to occur, and how this compares with time allowed for care proceedings.

2.14 Effectiveness of web-based parenting programmes

Research question

Are web-based parenting programmes effective and cost effective for improving parenting and preventing recurrence of abuse and neglect in families where abuse or neglect has occurred?

Why this is important

There is a lack of research data about the impact of web-based parenting programmes on families where abuse or neglect has occurred. Our review for this guideline identified one small-scale US study of a web-based parenting programme for parents of children with abusive head injury (Mast et al. 2014 -). Research would inform practitioners whether this type of parenting programme could be effective for families where abuse or neglect has occurred, and if so which families would be most likely to benefit.

Criterion	Explanation
Population	Parents/carers in families where abuse/neglect has occurred
Intervention	Web-based parenting programme
Comparators	No intervention/waitlist.
Outcomes	Reduced incidence of abuse and/or neglect Reduced risk of abuse and/or neglect Improved parent-child relationships Wellbeing of children and young people Wellbeing of parents/carers
Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions, or other types of evaluation with the aim of ascertaining whether web-based parenting programmes are effective. It will also be important to gain children, young people, parent/carer and practitioners' feedback as part of any studies.
Timeframe	Studies would require sufficient follow-up time to capture impacts on wellbeing and incidence of abuse or neglect.

2.15 Relative effectiveness of interventions to support foster carers

Research question

What is the relative effectiveness and cost effectiveness of the KEEP intervention for foster carers of abused or neglected children compared to other interventions?

Why this is important

There has been no independent UK study of the relative effectiveness of the KEEP intervention for foster carers and abused or neglected children when compared head to head with other interventions for foster carers. (There are effectiveness studies, but these are with a waitlist or service as usual comparator, rather than comparing different forms of support 'head to head'.) Data about outcomes in fostering services which use the KEEP model are kept by the National Implementation Service, which has responsibility for ensuring that model fidelity is maintained, but does not make comparisons with outcomes of other intervention models. A comparison study would help service providers identify the most appropriate model for supporting foster carers and abused or neglected children.

Criterion	**Explanation**
Population	Foster carers caring for abused/neglected children
Intervention	KEEP intervention
Comparators	Other programmes of support for foster carers
Outcomes	Wellbeing of children and young people Improved carer/child relationships Improved wellbeing of carers
Study design	To add to evidence already identified in this guideline, study design would need to be a head to head randomised control trial comparing KEEP with one or more other programmes of support for foster carers. It would also be useful to gain children, young people, parent/carer and practitioners' feedback as part of a study in to this intervention.
Timeframe	Study would require sufficient follow-up time to capture impacts on wellbeing.

2.16 Peer support for children and young people who have been abused or neglected

Research question

What peer support programmes are effective and cost effective in improving the wellbeing of children and young people who have been abused or neglected?

Why this is important

There is a small amount of research into peer support interventions for children who have been abused or neglected (Fantuzzo et al. 2005−). There is also anecdotal evidence that children who have experienced abuse or neglect would appreciate formally organised peer support in addition to the informal peer support that children often provide each other. A research study, where careful consideration was given to issues like helping peer supporters to manage confidential information about abuse or neglect, could test the success of a formally organised peer support programme.

Criterion	Explanation
Population	Children and young people who have experienced abuse and/or neglect.
Intervention	A formal peer support programme in which maltreated children and young people are paired up with non-maltreated children and young people as a way of improving their social skills and confidence.
Comparators	No intervention/waitlist.
Outcomes	Abused or neglected children and young people's wellbeing Peer supporters' wellbeing.
Study design	Study designs could include cost-effectiveness studies and RCTs of specific interventions, or other types of evaluation with the aim of ascertaining whether peer support is effective in improving wellbeing for abuse or neglected children and young people. The study would need to measure outcomes both for the abused or neglected children and also for peer supporters, including ensuring that there were no adverse effects for peer supports. Qualitative feedback from abused or neglected children and peer supporters would also be helpful.
Timeframe	Studies would require sufficient follow-up time to capture impacts on wellbeing.

3 Evidence review and recommendations

When this guideline was started, we used the methods and processes described in the Social care guidance manual (2013). From January 2015, we used the methods

and processes in Developing NICE guidelines: the manual (2014). For more information on how this guideline was developed, see Appendix A.

Searching

A single broad search was undertaken, combining search terms across all review questions. Evidence was searched from 2004, the year of publication of the Children Act 2004 which amended the legal framework for responding to concerns about the abuse and neglect of children. An update search was carried out in April 2016 to identify any new studies published since the original searches were conducted relating to the effectiveness questions (5, 7, 9-13, 15-19). This search used the same search terms and databases as the main search. The full set of results was then used as a 'database' within which to search for studies relevant to the effectiveness questions. We did not seek new evidence on the questions relating to views and experiences of aspects of professional practice (1, 2, 6, 8, 14, 20 and 21) as we had found a good volume of evidence in the original studies, and considered the themes identified to be well saturated and supported. We did not seek new evidence through the update searches for questions on recognition indicators (3 and 4) as this evidence base was considered to be relatively stable. For more information see Appendix A.

Screening

Search outputs were screened in several stages. Initially, all search outputs were screened on title and abstract against the following broad set of exclusion criteria:

- date (not published before 2004)
- language (must be in English)
- duplicate (must not duplicate another study in the database)
- evidence type (must be an empirical research study, must not be dissertation thesis or conference abstract/paper)
- population (must relate to children and young people under 18 who are at risk of, or experiencing, abuse and neglect or their parents, families, carers and household members; professionals working with these groups)
- topic (study does not relate to recognition, assessment, targeted primary prevention, secondary/tertiary prevention of child abuse and neglect, or

organisational factors associated with professional practice in relation to abuse/neglect)
- insufficient information (study abstract not provided and title does not suggest relevance)
- study withdrawn (must not be a study which has been withdrawn).

At the first stage of screening, a large number of records were excluded on evidence type (dissertations and conference abstracts) and as duplicate records. Of the remaining records, a random sample of 5% were double-screened.[2] Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific criteria for those questions, based on the PICO criteria for that question. These are described in sections 3.1 to 3.10 below. Full texts were retrieved for studies included at this stage, and screened again.

Where there were existing systematic reviews which met our PICO and evidence criteria, these were used as the basis for review and updated as appropriate. If all studies in a systematic review did not meet our PICO, and the results were sufficiently disaggregated, we extracted data from applicable studies only. Where results were not sufficiently disaggregated, we excluded the systematic review and used individual studies identified by our searches for that question. Where studies appeared in several included systematic reviews, and it was possible to disaggregate at study level, results were included from 1 review only to avoid double-counting. We did not apply a date cut-off to studies included via systematic reviews, on the grounds that this provided a means to incorporate relevant research from prior to the 2004 cut-off.

Critical appraisal

The included studies were critically appraised using tools adapted from the NICE manual (and agreed with NICE) and the results tabulated. Studies were rated for internal and external validity using ++/+/- (meaning good, moderate and low). The 2 scores were then combined in to a single score, which was weighted towards internal validity (that is, the combined quality rating could not be higher than the

[2] Double screening of 5% rather than 10% of records was due to high volume of search outputs.

internal validity score). Reviewer judgement was used where external validity was lower than internal validity about whether to 'downgrade' the overall quality rating. See Appendix B for all tables and quality ratings.

Presentation of review evidence

Review questions 1-20 were structured according to a broad care pathway (recognition, assessment, early help, and response). For each area of the care pathway we sought:

- effectiveness evidence (review questions 5, 7, 9-13 and 15-19)
- information about what helps and hinders professional practice (review questions 6, 8, 14 and 20)
- views and experiences of children, young people, adult survivors of child abuse, parents and carers and practitioners (review questions 1 and 2).

There were also 2 questions relating to recognition about risk factors and indicators of abuse in children and parents (questions 3 and 4) and an overarching question about organisational factors that help and hinder multi-agency working (question 21).

We aimed to present the views and experiences evidence alongside the relevant part of the care pathway. In practice, there was considerable overlap between these questions and the questions on what helps and hinders professional practice. The review protocols and results relating to views and experiences evidence (review questions 1 and 2) is therefore presented as part of the evidence for questions 6, 8, 14, 20 and 21 (sections 3.3, 3.5, 3.7, 3.9 and 3.10). Some views data are also presented alongside the results for question 9 (section 3.6).

Synthesis

For questions 6, 8, 14, 20 and 21 and associated views and experiences data from questions 1 and 2 the findings from the studies have been synthesised thematically. For each question we developed a set of inductive thematic categories based on the data. Using Excel, extracted data from each study was mapped against these categories. Thematic categories were quality assured by the lead systematic reviewer as appropriate. For questions 3 and 4 (recognition indicators) results are presented according to risk factor/indicator type.

For questions 9-13 and 15-19 a narrative synthesis of effectiveness evidence regarding interventions was conducted, grouped using the 7 outcome areas for these questions: incidence of abuse and neglect, risk of abuse and neglect, quality of parenting and parent-child relationships, children's health and wellbeing, caregiver/parent's health and wellbeing and service outcomes. Statistical meta-analysis was considered for these questions. However, preliminary analyses identified significant inconsistency in outcome measures across studies. The data were therefore judged to be unsuitable for statistical meta-analysis[3]. As results were not being combined meta-analytically, effect sizes were reported as calculated by the study authors where available (otherwise Cohen's d was calculated by the review team where possible). The magnitude of the effect size was also described using the following conventions:

	Cohen's d or h, standard mean difference	Partial eta squared	Phi
Small	0.2	0.02	0.1
Medium	0.5	0.13	0.3
Large	0.8	0.26	0.5

For questions 5 and 7, only one study for each question was identified that was considered of adequate quality to inform an evidence statement, meaning that synthesis across studies was not possible.

Links with previous clinical guideline on child maltreatment

This guideline sought to build on, and avoid duplication with, the previous clinical guideline on child maltreatment, which contains recommendations on alerting features for child maltreatment within the context of a presentation to a healthcare professional. The current guideline aimed to extend this work to include alerting features (here referred to as indicators) which could be observed by other practitioners such as social workers. This included a focus on parents and parent-child interactions outside of a healthcare context.

[3] Higgins JPT, Green S (editors). *Cochrane Handbook for Systematic Reviews of Interventions* Version 5.1.0 [updated March 2011]. The Cochrane Collaboration, 2011. Available from http://handbook.cochrane.org.

The relevant review questions therefore focused on non-clinical indicators of abuse and neglect, and were worded as follows:

- What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect?
- What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect?

A single broad search was undertaken for these questions as part of the main search. During screening of search results, we screened out evidence on alerting features that were covered in the previous guideline. We also agreed a list of social and behavioural indicators with the guideline committee that were a priority for consideration (see Section 3.1).

Although the main focus of the previous guideline was clinical, evidence had been considered relating to emotional, behavioural, interpersonal and social functioning and neglect, and recommendations formulated. The review questions used to develop these aspects of the previous guideline were considered to be similar to our review questions. In line with Section 8.1 of the NICE manual, we therefore reviewed this evidence and presented it to the committee. The committee decided whether to adopt recommendations from the previous guideline, or to adapt with amendments to wording. Where amendments to wording were proposed, a clear rationale was given, and were agreed with NICE.

Children and young people's expert reference group

We were keen to ensure that children and young people were involved in the development of the guideline. Through scoping work and discussions with the guideline committee, it was decided that the most appropriate way to engage children and young people was via a separate ‘expert reference group’ that would meet at several points during development. This was thought to be the best way to ensure that participation would be meaningful, fully supported, and able to be tailored to young people’s needs.

The objectives of the expert reference group were to:

- Provide insight about their perspectives on specific questions and issues identified by both the guideline committee and themselves.
- Comment on the recommendations made by the guideline committee
- Contribute ideas to a possible 'Information for young people' version of the final guideline, and, along with the guideline committee, to wider dissemination and implementation of the guideline (this will be undertaken after publication).

An external specialist facilitator was appointed to run the group. Fifteen young people were recruited to the group: 4 male and 11 female with an age range of 14-21. All young people had experienced various forms of abuse and/or neglect and the group included looked after children and teenage mothers.

The expert reference group met four times between November 2015 and November 2016. Three meetings broadly mirrored the agenda of the committee (early help; recognition and assessment; response) and one was to give feedback on the full set of draft recommendations. The group also had a joint meeting in June 2016 in London with members of the guideline committee.

For more information on the children and young people's expert reference group see Appendix E.

3.1 Recognition of abuse and neglect – risk factors and indicators

Introduction to the review question

Children, young people, parents and carers do not always tell practitioners about abuse and neglect directly, but may signal indirectly via their emotional states and behaviour. Some children and young people are also at greater risk of abuse and neglect than others.

The purpose of these review questions was to assess what characteristics put some children at greater risk of abuse and neglect (risk factors), and what emotional states, behaviour and social functioning are associated with abuse and neglect (indicators), with the purpose of assisting recognition by practitioners. The questions

looked at risk factors and indicators associated with children and young people, as well as parents and carers. The questions focused on areas not already covered by the NICE guideline on child maltreatment.

We sought to answer this question using studies comparing the prevalence of particular risk factors and emotional, social and behavioural indicators among caregivers and families where abuse is occurring, compared to those where it is not. Due to the high volume of evidence in this area, these reviews focused on existing systematic reviews and meta-analyses covering a set of areas identified by the Guideline Committee as priorities. As no systematic reviews were identified regarding the association between language development and abuse or neglect, and this was considered a high priority, we conducted an additional systematic review of papers on this topic.

The quality of the studies was generally moderate, although it is worth noting that few of the systematic reviews in this area conducted critical appraisal of the included studies. For effectiveness questions, systematic reviews with no critical appraisal would have been excluded. However, consultation with experts ascertained that lack of critical appraisal was common for these types of reviews, and there are few tools available for appraising the types of studies that the reviews included. We therefore decided to include systematic reviews that had not conducted critical appraisal of included studies for these questions.

Review questions

3. What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect?

4. What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect?

Summary of the review protocol

For question 3, the protocol sought to identify studies that would:

- assess what characteristics put some children at greater risk of abuse and neglect, with the purpose of assisting recognition

- assess how experiencing abuse and neglect may affect children and young people's emotional states, behaviour and social functioning with the purpose of assisting recognition
- focus on areas not covered in the NICE guideline on child maltreatment.

For question 4, the protocol sought to identify studies that would:

- assess what parental and family characteristics put some children and young people at greater risk of abuse and neglect, with the purpose of assisting recognition
- assess what caregiver behaviours are associated with the abuse and neglect of children and young people with the purpose of assisting recognition
- assess what aspects of family functioning are associated with the abuse and neglect of children and young people with the purpose of assisting recognition
- focus on areas not covered in the NICE guideline on child maltreatment.

The study designs included for these questions were longitudinal and cohort studies, cross-sectional studies, case control studies, and systematic reviews and meta-analyses of the above.

Full protocols can be found in Appendix A.

Population

Children and young people (under 18) who are at risk of, are experiencing, or have experienced abuse or neglect.

The caregivers and families of children and young people (under 18) who are experiencing, or have experienced abuse or neglect.

Intervention

Not applicable.

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children's own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings
- schools and colleges
- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Children and young people's health and wellbeing; parents' health and wellbeing.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM)); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials registries were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and October 2014. Update searching of the bibliographic database searches took place in April 2016.

Summary from re-run searches

An updated search was carried out in April 2016 to identify any new studies relating to the effectiveness questions (5, 7, 9-13, 15-19) published since the original searches were conducted for this guideline. This search used the same search terms and databases as the main search.

As we originally conducted a single search for all of the original 21 questions, the search identified a large number (10,833) of items which we used as a 'database' within which to search for studies relevant to our questions. This included specific searches for interventions for which evidence had already been reviewed.

We were unable to find an existing systematic review of the relationship between experience of maltreatment and language ability and development. We therefore undertook a search within our database of studies relating to language. See Appendix A for full details of the search and additional search terms.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope.

Search outputs were screened in several stages as described at the beginning of section 3. Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific criteria for those questions.

For questions 3 and 4 these were as follows:

- evidence type (study must be a longitudinal, cohort, cross-sectional or case control study or systematic review/meta-analysis of studies of these designs)
- population (children and young people under 18 who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families)
- indicator type (must not be clinical indicators and those already covered in NICE guidance on child maltreatment).

Using these criteria, we identified an extremely high number of potentially relevant studies (n=4065). Given the extremely high number of results for this question, we therefore focused on a set of indicators thought to be of particular relevance to the social care focus of this guideline. These were agreed with the Guideline Committee Chair, and in a meeting with a subset of the Guideline Committee, and were as follows:

- antisocial behaviour
- anxiety disorders
- behaviour
- bullying
- children's drawings
- criminal behaviour
- disability (as a risk factor)
- disclosure
- educational outcomes
- general recognition
- language development
- risk factors (general)
- sleep disturbance

- socio-emotional development
- substance misuse by young people
- suicidal behaviour
- victimisation
- views and experiences.

We further agreed that we would conduct full text review for systematic review and meta-analysis evidence only, where these were available on the priority topics.

We identified 112 meta-analyses and systematic reviews in total. We conducted full text review of 53 papers (66 reviewed at stage 3, 13 of which were papers about language), focusing on the list of indicators developed by the Guideline Committee Chair and subgroup. This resulted in the inclusion of 15 systematic reviews in total, 13 which were primarily about risk factors and indicators relating to children and young people, and 2 which were primarily about parents and carers.

Our sub-search for papers relating to language development resulted in 13 papers, 9 of which were included following full text screening.

Included papers were critically appraised using tools agreed by NICE and data extracted using a coding set developed to reflect the review questions. See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence

Part A - Indicators relating to children

1. Emotional, behavioural and developmental indicators

Description of evidence

We found 2 moderate-quality systematic reviews (Evans et al. 2008 +; Luke and Banerjee 2013 +), and 1 poor quality review (Naughton et al. 2013 -) which examined the association between maltreatment and indicators relating to emotion, behaviour or development.

The 2 moderate-quality reviews each had a relatively specific focus. Evans et al. (2008 +) conducted a review of 60 studies conducted between 1990 and 2006,

reporting on the association between exposure to domestic violence and internalising and externalising behaviours and trauma symptoms in children under the age of 18. No information was available regarding the countries in which studies were conducted. The reviewing team was based in the USA.

Luke and Banerjee (2013 +) conducted a review which included a meta-analysis of 19 studies on emotion skills in maltreated and non-maltreated children, as well as a narrative review of 51 studies in total. Only the results of the meta-analysis are reported here, as the narrative review provides no data on effect sizes or significance levels. All studies included in the meta-analysis were with children under the age of 18. 'Emotion skills' are described as comprising aspects of social understanding such as emotion recognition, emotion understanding and emotion knowledge. The 19 studies included in the meta-analysis were conducted in the USA (17 studies), UK (1 study) and Australia (1 study).

Finally, Naughton et al. (2013 -) reviewed 35 case-control, cross-sectional and cohort studies across a range of emotional, behavioural and developmental indicators in children aged 0 to 6 years. Two of the included studies were conducted in Canada, and the remainder in the USA. The reviewing team were based in the USA. The findings of their review are reported in the 'Other emotional, behavioural and developmental features' section below, and we have also indicated where studies they have included relate to indicators explored in Evans et al. (2008 +) or Luke and Banerjee (2013 +). This study was rated as poor quality because, although critical appraisal was reportedly conducted, it was unclear how this was used within the analysis. It was also unclear how the study results were combined to arrive at the lists of indicators presented, and there was poor reporting of statistical data from the original studies.

Internalising behaviour

In Evans et al. (2008 +), 58 studies (total n=7602) examined the association between childhood exposure to domestic violence, and 'internalising behaviours' in children. No additional definition of 'internalising behaviours' is provided in the paper. The pooled mean effect size indicated a correlation between exposure to domestic violence and internalising behaviours with small to medium effect size (weighted mean effect size =0.48; 95% confidence interval 0.39 to 0.57, $p<0.01$). There was no

significant difference in internalising behaviour in girls exposed to domestic violence versus boys exposed to domestic violence (Qb(1)=0.34, p=0.56), or for the different age groups of early childhood, middle childhood and adolescence (Qb(2)=0.17, p=0.92).

Naughton et al. (2013 -) cite a further 2 US prospective cohort studies which examined the association between neglect and internalising behaviours. The first study found that, at age 3, psychological neglect was significantly associated with children's internalising behaviour problems (p<0.01, no odds ratios reported) and externalising behaviour problems (p<0.001, no odds ratios reported) (Dubowitz et al. 2002, cited in Naughton et al. 2013 -). A second study taking measures at ages 5 and 6 found that environmental neglect was significantly related to internalising behaviour problems as reported by mothers (p<0.001) but not reported by teachers (p=not reported) (Dubowitz et al. 2004, cited in Naughton et al. 2013 -).

Externalising behaviour

In Evans et al. (2008 +), 53 studies (total n=7200) examined the association between childhood exposure to domestic violence and externalising behaviours in children. No additional definition of 'externalising behaviours' is provided in the paper. There was a significant association between exposure to domestic violence and externalising behaviours, with small to medium effect size (weighted mean effect size =0.47, 95% confidence interval 0.38 to 0.56, p<0.01). The relationship between exposure to domestic violence and externalising behaviour was stronger in boys than girls (Qb(1)=4.11, p<0.05), with a small to medium effect size for boys (mean effect size=0.46, no confidence intervals reported) and a small effect size for girls (mean effect size=0.23, no confidence intervals reported). There was no significant difference in the association between domestic violence and externalising behaviour for different age groups (preschool, school age and adolescent) (Qb(2)=0.59, p=0.75).

Naughton et al. (2013 -) cite a further 4 studies which found a significant relationship between neglect and externalising and aggressive behaviour (Dubowitz 2002, 2004; English 2005; Erickson 1989, cited in Naughton et al. 2013 -). These studies found that psychological neglect at age 3 was significantly associated with externalising behaviour (p<0.001) (Dubowitz 2002 cited in Naughton et al. 2013 -), and in a

longitudinal study taking measurements at ages 5 and 6 that environmental neglect was significantly related to behaviour problems and externalising behaviour, as reported by mothers ($p<0.001$) (Dubowitz 2004 cited in Naughton et al. 2013 -). English et al. (2005 cited in Naughton et al. 2013 -) found that verbal aggression and verbally aggressive discipline by the parents were associated with aggressive behaviours in children ($p<0.001$). Erickson et al. (1989 cited in Naughton et al. 2013 -) found that emotionally neglected children had the highest scores on the externalising behaviour scale ($p<0.01$) compared to neglected, physically abused, sexually abused or control children. Odds ratios/effect sizes are not reported.

Trauma symptoms

In Evans et al. (2008 +), 6 studies (total n not reported) examined the association between childhood exposure to domestic violence and trauma symptoms, such as 'intrusive re-experiencing of events in dreams or flashbacks, hyperarousal or an exaggerated startle response, and emotional withdrawal' (Evans et al. 2008, p132). There was a significant association between exposure to domestic violence and trauma symptoms, with large effect size (mean effect size =1.54, 95% confidence interval 0.38 to 2.71, $p<0.01$). However, it should be noted that this estimate is based on a relatively small number of studies (n=6). Due to the small number of studies measuring trauma symptoms, only overall weighted mean was calculated – no subgroup analyses were undertaken.

'Emotion skills'

The link between physical abuse or neglect and emotion skills was explored in a meta-analysis of 19 studies by Luke and Banerjee (2013 +). The criteria for inclusion of studies were that they should provide behavioural data comparing maltreated children (who have experienced parental physical abuse and/or neglect) and non-maltreated children on measures of emotion recognition, emotion understanding or emotion knowledge (termed collectively 'emotion skills'). The included studies use a variety of measures including labelling emotions, assigning intent to story characters and matching emotion pairs.

Sixteen of the 19 included studies (84.2%) showed effect sizes in the expected direction: that is, maltreatment status or severity was associated with poorer emotion skills. The weighted mean effect size across the 19 studies showed a medium to

large effect size in the direction of maltreated children demonstrating poorer emotional skills (d=-0.696; 95% CI-0.985 to -0.406).

A moderator analysis found that the age group of participants (early childhood, middle child, adolescence) moderated effect size (Q(2)=11.320 (between groups); p=.003). It was found that studies conducted in early childhood showed larger effect sizes than those conducted in middle childhood (d=-0.933; 95% CI-1.160 to -0.706, compared to d=-0.776; 95% CI -1.315 to -0.236), which in turn had larger effect sizes than those in adolescents (d=0.042; 95% CI-0.479 to -0.563). In fact, studies conducted in adolescence showed a very small and non-significant effect.

A second moderator analysis examining the effect of choice of outcome variable was conducted. The results suggested that the type of outcome measure did moderate the findings (Q(2)=13.001, p=0.002), with studies measuring emotion understanding showing larger effect sizes than those measuring composite emotion knowledge (d=-1.351; 95% CI-2.311 to -0.392 compared to d=-0.972; 95% CI-1.258 to -0.686), which in turn were larger than those measuring emotion recognition (d=-0.309; 95% CI-0.580 to -0.039). The authors note that this may be because emotion understanding is a more advanced skill, and so may be 'particularly susceptible to the deleterious effects of maltreatment experiences' (Luke and Banerjee 2013, p20).

Naughton et al. (2013 -) cite a further 3 studies not included in Luke and Banerjee which explore the association between emotional abuse or neglect and emotion skills. One case control study found that neglected children portrayed children in a story stem task as responding less often to relieve distress in other children (Macfie et al. 1999, cited in Naughton et al. 2013 -, no statistical data reported). A second prospective cohort study (Sullivan et al. 2008 cited in Naughton et al. 2013 -) found that neglected children had early deficits in emotional knowledge across all 3 components of labelling ($p<0.01$), visual recognition (no statistical data reported) and matching context (no statistical data reported). A third study (Pollak et al. 2000 cited in Naughton et al. 2013 -) found that neglected children also showed difficulties with discrimination of emotion expressions such as anger ($p<0.05$) and disgust ($p<0.01$).

Other emotional, behavioural and developmental features

Naughton et al. (2013 -) conducted a wide-ranging review of 35 studies examining the association between emotional abuse and neglect and emotional, behavioural and developmental features. The review concludes that 'these features should alert social and health care professionals to children who warrant detailed evaluation and family intervention' (p772). The reviewers analysed the studies according to the ages of the children involved and concluded that the following features were associated with emotional abuse and neglect.

0 to 20 months: The features identified were higher rates of insecure-avoidant attachment (Crittenden 1985, cited in Naughton et al. 2013 -, no p values or effect sizes given; Lamb et al. 1985, cited in Naughton et al. 2013 -, $p<0.005$ but unclear comparison group) and insecure-disorganised attachment (Cicchetti et al. 2006, cited in Naughton et al. 2013 -, $p<0.001$ but unclear comparison group). The review also concludes that neglected children show poorer cognitive skills and developmental delay, with 1 study finding that the cognitive performance of children with neglect and failure to thrive was significantly lower than those with neglect only ($p<0.01$), failure to thrive only ($p<0.01$) or a control group ($p<0.01$) (Mackner et al. 1999, cited in Naughton et al. 2013 -), and a second that language delay in neglected children was moderate by risk factors include maternal maltreatment and depression (Sylvestre and Merette 2010, cited in Naughton et al. 2013 -). However, 1 study found that neglected children were no different from non-maltreated control on complexity of play style or cognitive abilities (Valentino et al. 2006, cited in Naughton et al. 2013 -, no statistical data reported). A final study found higher rates of passive withdrawn behaviour (Crittenden and DiLalla 1988, cited in Naughton et al. 2013 -, no statistical data reported).

20 to 30 months: Features identified were increased negativity in play among neglected children (DiLalla and Crittenden 1990, cited in Naughton et al. 2013 -, $p<0.001$), reduced social interactions, for example being more likely to be isolated during free play ($p<0.01$) (Crittenden 1992, cited in Naughton et al. 2013 -) and deficits in memory performance in comparison to both abused and matched controls ($p<0.001$) (Cheatham et al. 2010, cited in Naughton et al. 2013 -).

3 to 4 years: Features identified were negativity in play (Koenig et al. 2000, cited in Naughton et al. 2013 -, no statistical data reported), delays in complex language, including comprehension and expressive language abilities ($p<0.001$) (Allen and Oliver 1982; Culp et al. 1991, both cited in Naughton et al. 2013 -, no statistical data reported); and difficulties with emotion discrimination (Frodi and Smetana 1984, cited in Naughton et al. 2013 -).

4 to 5 years: Features identified were poor peer relationships, poor social interaction, greater aggression and conduct problems. Neglected children engaged in the least number of interactions with other children, especially prosocial behaviour ($p<0.05$) (Hoffman-Plotkin and Twentyman 1984, cited in Naughton et al. 2013 -) and higher ratings of 'dysfunction' (Rohrbeck and Twentyman 1986, cited in Naughton et al. 2013 -, $p<0.05$). One study also found delays in complex language in this age group, with maltreated children showing a 16-month delay in syntactic development for language compared with 13 months for controls; scores on Peabody picture vocabulary test were lower in maltreated groups compared with controls ($p<0.04$) (Eigsti et al. 2004, cited in Naughton et al. 2013 -). Neglected children also showed difficulties with discrimination of emotion expressions such as anger ($p<0.05$) and disgust ($p<0.01$) (Pollak et al. 2000, cited in Naughton et al. 2013 -). The review also concludes that neglected children are more likely to show dysregulation of emotion patterns, with neglected children having increased odds of under-controlled or ambivalent emotional responses by a factor of 7.5 ($p<0.001$) and over-controlled/unresponsive emotion by a factor of 5.9 ($p<0.01$) (Maughan and Cicchetti 2002, cited in Naughton et al. 2013 -). One study also found that neglected children were more likely to have a helpless outlook, and not view others as a source of help (Macfie et al. 1999, cited in Naughton et al. 2013 -, no statistical data reported).

5 to 6 years: Features identified were higher rates of insecure-avoidant attachment ($p<0.01$) (Venet et al. 2007, cited in Naughton et al. 2013 -); a greater tendency towards poor peer relationships (Macfie et al. 2001, cited in Naughton et al. 2013 -, no statistical data reported); and a greater tendency to rate self as angry and oppositional ($p<0.05$), and others as sad/hurt ($p<0.01$) (Waldinger et al. 2001, cited in Naughton et al. 2013 -). One study found that neglected children had lower self-esteem ($p<0.01$) (Toth et al. 1997, cited in Naughton et al. 2013 -) and greater

inclination to cheat ($p<0.01$) and break rules ($p<0.05$) (Koenig et al. 2004, cited in Naughton et al. 2013 -).

2. Interactions with caregivers

Description of evidence

We found 1 moderate-quality US systematic review (Wilson et al. 2010 +) that reviewed 30 studies from 1994 to 2008 in order to assess how physically abused and neglected children are distinguished from non-maltreated children during interactions with their parents. The review examined 3 behavioural 'clusters': positivity (for example, affection, approval); aversiveness (for example, anger, resistance) and involvement (for example, attention, interest).

The studies included in the review were conducted in the USA (26 studies), Spain (2 studies) and Canada (2 studies). The mean age of children included in the studies ranged from 1.2 to 11.5 years. Studies were only included if the main sample were children who had a history of involvement with child protective services (as identified through administrative data, professional report or parent self-report), if they included a comparison sample of non-maltreated children and if parent–child interactions were measured via observational (rather than self-report) measures.

The study was rated as moderate quality as there were clear inclusion and exclusion criteria, a comprehensive search strategy and clear a methodology for analysing data, but no critical appraisal of the included studies.

A second poor quality US systematic review (Naughton et al. 2013 -) also reported on 4 studies which included measures of child interaction with caregivers, 2 of which were not covered by the Wilson et al. (2010 +) study.

Positivity

In Wilson et al. (2010 +), measures coded by the review authors into the category of 'positivity' included verbal and physical communication, compliance, cooperation, enthusiasm, positive affect and prosocial behaviour by the child. Nineteen of the included studies included a measure in this category, based on a total of 1545 child participants and resulting in 24 effect sizes. These were pooled across studies to give a weighted mean effect size.

The mean weighted effect size across the studies for positive behaviour was a minimum estimate of d=0.42 (95% CI 0.30 to 0.54) and a maximum estimate of d=0.45 (95% CI 0.32 to 0.58): abused or neglected children were less likely to show positive behaviour, with medium effect size. Moderator analysis found that effect sizes were similar for different forms of abuse (physical abuse 0.44, no confidence intervals reported; neglect 0.51, no confidence intervals reported), suggesting that rates of positive behaviour were equally useful for distinguishing both physically abused and neglected children from non-maltreated children.

Further moderator analysis identified that child age was inversely related to effect size in child positivity, with marginal statistical significance (r=-0.36, p=0.08). The effect size in maltreated compared to non-maltreated children in relation to positivity for children under 4.5 years of age was medium (d=0.57, no confidence intervals reported), whereas for children aged over 4.5 years it was small (d=0.25, no confidence intervals reported). The authors suggest that rates of positive behaviour are therefore more useful for distinguishing maltreated from non-maltreated children in younger compared to older children. The impact of observation length on effect sizes was not explored for this variable.

Aversiveness

In Wilson et al. (2010 +), measures coded by the review authors into the category of 'aversiveness' included noncompliance, verbal and physical aggression, hostility and negative mood. Twenty-four of the included studies included a measure in this category, based on a total of 1868 child participants and resulting in 29 effect sizes.

The mean weighted effect size across the studies for aversive behaviour was a minimum estimate of d=0.31 (95% CI 0.16 to 0.46) to maximum 0.29 (95% CI 0.12 to 0.46), meaning that abused or neglected children were more likely to show aversive behaviours, with small to medium effect size. Moderator analysis found that effect sizes for aversiveness were similar for different forms of abuse (physical abuse d=0.29, no confidence intervals reported; neglect d=0.30, no confidence intervals reported), suggesting that rates of aversive behaviour were equally useful for distinguishing both physically abused and neglected children from non-maltreated children. The impact of the age of the child was not explored for this variable.

Involvement

In Wilson et al. (2010 +), measures coded by the review authors into the category of 'involvement' included social interaction, requesting information, pointing/social referencing and responding to the caregivers' engagement. Seventeen of the included studies included a measure in this category based on a total of 1136 child participants and resulting in 22 effect sizes.

The mean weighted effect size across the studies for involvement was a minimum estimate of d=0.51 (95% CI 0.25 to 0.77) to maximum d=0.55 (95% CI 0.29 to 0.81), meaning that abused or neglected children were less likely to show involvement with their caregivers, with medium effect size.

Moderator analysis found that effect sizes for involvement were more pronounced for neglected children (d=0.75, no confidence intervals reported) than for physically abused children (d=0.39, no confidence intervals reported), suggesting that rates of involvement behaviours are more useful for identifying neglected children than physically abused children. However, the study authors encourage caution in this conclusion due to the heterogeneity of effect sizes between the studies, and relatively small number of effect sizes for the neglect group (k=6). The impact of the age of the child and observation length was not explored for this variable.

Passivity

A poor quality US systematic review (Naughton et al. 2013 -) also reported on 2 studies which were not covered in the Wilson et al. (2010 +) study which were relevant to negative parent–child interactions. One study (Crittenden 1985, cited in Naughton et al. 2013 -) of infants with a mean age of 13.7 months found that neglected infants had a passive behaviour pattern of interaction with their mothers. The review cites that this is statistically significant ($p<0.001$), however it is not clear against which group this is being compared. A second study (Crittenden and DiLalla 1988, cited in Naughton et al. 2013 -) of infants with a mean age of 18.5 months found that neglected children were more passive initially but as they became older (12 months onwards up to 2 and a quarter) their negative behaviours increased.

3. Bullying

Description of evidence

We found 1 moderate-quality UK systematic review (Lereya et al. 2013 +), examining the association between parenting behaviours and likelihood of being bullied or of being a 'bully/victim' (a child who both bullies others, and is a victim). A key limitation of this study was that the authors did not critically appraise the quality of included studies. However, the rest of the systematic review was of high quality, and statistical data is well reported

The authors review 70 studies in total, 6 of which relate specifically to the relationship between abusive parenting and being bullied or being a bully/victim. The 6 studies were conducted in Europe (4 studies, no further detail given), the US (1 study) and 'other' (1 study). In the studies, bullying was variously measured by self, peer, teacher and parent report, and included physical, verbal and/or cyber victimisation.

Being a victim of bullying

The association between abuse and neglect and being a victim of bullying was explored in 6 studies (Bowes et al. 2009; Dehue et al. 2012; Kelleher et al. 2008; Mohr 2006; Schwartz et al. 2000; Shin and Kim 2008 cited in Lereya et al. 2013 +). The total number of participants across the 6 studies was 5289, with ages ranging from 4 to what the authors describe as '12+'.

Four of the 6 studies found a statistically significant relationship between experiencing abuse and neglect and being a victim of bullying. A meta-analysis of the 6 studies found that, overall, children who had been abused or neglected were more likely to be the victims of bullying, with small effect size (Hedge's g=0.307, 95% confidence interval 0.175 to 0.440).

Being a bully/victim

The association between abuse and neglect and being a bully/victim was explored in 3 of the included studies (Bowes et al. 2009; Dehue et al. 2012; Mohr 2006 cited in Lereya et al. 2013 +). The total number of participants across the 3 studies was 4149, age ranges from 4 to 12. All 3 studies found statistically significant relationships between being a victim of abuse/neglect and being a bully/victim. A

meta-analysis found a medium to large overall weighted effect size (g=0.680, 95% CI 0.440 to 0.919).

4. Substance misuse by children and young people

Description of evidence

We found 1 poor quality Canadian systematic review (Tonmyr et al. 2010 -) of a total of 31 studies conducted in the USA (22 studies), Australia (1 study), New Zealand (1 study), France (1 study), Sweden (1 study), Denmark (1 study), the Netherlands (1 study), Hong Kong (1 study), Norway (1 study) and Taiwan (1 study) from the start date of numerous bibliographic databases (exact date unclear) until March 2010.

The review examined the relationships between various forms of abuse: physical, sexual and emotional abuse; neglect (supervisory, physical, medical, emotional, educational) and witnessing domestic violence; and misuse of nicotine, alcohol and drugs (cannabis, glue and solvents, barbiturates, heroin, methamphetamine, stimulants, LSD, PCP, ecstasy and methylphenidate) among young people aged 12 to 18.

The systematic review was rated as poor quality due to lack of critical appraisal of included papers, and because statistical significance data is not reported for all papers. The review is a narrative review, reporting odds ratios and risk ratios where available, but does not calculate pooled odds ratios for the included studies. The authors do not state why this was not conducted.

Drug use

Ten studies reported on the association between physical abuse and drug use/abuse (Hernandez et al. 1993; Hibbard et al. 1988; Hibbard et al. 1990; Kilpatrick et al. 2000; Lau et al. 2003; Logan et al. 2009; Moran et al. 2004; Perkins and Jones 2004; Riggs et al. 1990; Southwick-Bensley et al. 1999, cited in Tonmyr et al. 2010 -). All of these studies found a significant association between physical abuse and drug use/abuse, with participants who reported physical abuse being significantly more likely than those who did not report physical abuse to report drug use/abuse; with the exception of Riggs et al. (1990, cited in Tonmyr et al. 2010 -) which found that the association was not significant. Three studies (Hibbard et al. 1988; Kilpatrick et al. 2000 and Lau et al. 2003, cited in Tonmyr et al. 2010 -) all found a significant

association using more than 1 measure. Seven studies reported odds/relative risk ratios, which ranged between 1.8 (95% CI 1.7 to 4.9) and 20.4 (95% CI not reported).

Fifteen studies reported on the association between sexual abuse and drug use. Thirteen found that young people who had been sexually abused were significantly more likely to use drugs than those who had not, on at least 1 measure (Bergen et al. 2004; Champion et al. 2004; Choquet et al.1997; Edgardh and Ormstad 2000; Erickson and Rapkin 1991; Hernandez et al. 1993; Hibbard et al. 1988, Howard et al. 2005; Kilpatrick et al. 2000; Moran et al. 2004; Nagy et al. 1994; Southwick-Bensley et al. 1999; Watts and Ellis 1993, cited in Tonmyr et al. 2010 -). Six studies with statistically significant results reported odds/relative risk ratios, which ranged between 2.0 (95% CI 1.1 to 3.7) and 8.6 (95% CI not reported). Two studies did not find this effect (Hibbard et al. 1990; Riggs et al. 1990, cited in Tonmyr et al. 2010 -).

One study examined the association between emotional abuse and drug use (Moran et al. 2004, cited in Tonmyr et al. 2010 -), and found that young people who had been emotionally abused were not significantly more likely to use drugs, with an estimated odds ratio of 1.4 (95% CI not reported).

No studies examined the association between experiencing neglect or witnessing domestic violence and drug use.

Alcohol use

In Tonmyr et al. (2010 -) 14 studies explored the association between experiencing physical abuse and use of alcohol. Included measures related to ‘use’ and ‘consumption’ of alcohol, as well as indicators of more extreme behaviour such as ‘binge drinking’. Eleven studies (reported in 12 papers) found that young people who had been physically abused were significantly more likely to use alcohol than those who had not, on at least 1 measure (Fergusson et al. 1996, 1997; Frederiksen et al. 2008; Hamburger et al. 2008; Hibbard et al. 1988; Kilpatrick et al. 2000; Lau et al. 2003; Moran et al. 2004; Perkins and Jones 2004; Riggs et al. 1990; Shin et al. 2009; Yen et al. 2008, cited in Tonmyr et al. 2010 -). Seven of these studies reported odds ratios ranging from 1.3 (95% CI 1.0 to 1.8) to 8.9 (95% CI 2.5 to 32.1). Three studies found no significant relationship between physical abuse and alcohol use

(Hernandez et al. 1993; Hibbard et al. 1990; Southwick-Bensley et al. 1999 cited in Tonmyr et al. 2010 -).

Twenty-four studies explored the association between experiencing sexual abuse and use of alcohol. Twenty-two (reported in 23 papers) found that young people who had been sexually abused were significantly more likely to use alcohol than non-maltreated young people, on at least 1 measure (Behnken et al. 2010; Bergen et al. 2004; Champion et al. 2004; Choquet et al. 1997; Edgardh and Ormstad 2000; Erickson and Rapkin 1991; Fergusson et al. 1996, 1997; Garnefski and Arends 1998; Hamburger et al. 2008; Hernandez et al. 1992, 1993; Hibbard et al. 1988; Howard et al. 2005; Kilpatrick et al. 2000; Luster and Small 1997; Moran et al. 2004; Nagy et al. 1994; Nelson et al. 1994; Pedersen and Skrondal 1996; Shin et al. 2009; Southwick-Bensley et al. 1999; Watts and Ellis 1993, cited in Tonmyr et al. 2010 -). Eleven of these studies reported odds ratios, ranging from 1.8 (95% CI 1.1 to 3.0) to 5.2 (95% CI 2.7 to 9.8). Two studies did not find a significant relationship between sexual abuse and alcohol use on any measure (Chandy et al. 1997, Riggs et al. 1990, cited in Tonmyr et al. 2010 -).

One study examined the relationship between experiencing emotional abuse and use of alcohol (Moran et al. 2004, cited in Tonmyr et al. 2010 -), and found that young people who reported emotional abuse were significantly more likely than those who did not report emotional abuse to report alcohol use/abuse; 1.5 odds ratio (reported by review authors as significant but 95% CI is not reported).

Two studies examined the relationship between neglect and use of alcohol, 1 of which is reported in 2 papers (Clark et al. 2004, 2005; Shin et al. 2009, cited in Tonmyr et al. 2010 -). One study (Clark et al. 2004, 2005 cited in Tonmyr et al. 2010 -) found that there was a statistically significant relationship between experiencing neglect and using alcohol, producing 2 odds ratios of 3.2 (95% CI 1.3 to 8.3) and 21.2 odds ratio (95% CI 5.0 to 89.7). One study (Shin et al. 2009, cited in Tonmyr et al. 2010 -) did not find a significant relationship between neglect and alcohol use, reporting an odds ratio of 1.2 (95% CI 1.0 to 1.5).

Two further studies reported on the association between witnessing domestic violence and alcohol use/abuse (Hamburger et al. 2008; Simantov et al. 2000, cited

in Tonmyr et al. 2010 -, reported for both males and females). Both studies found an association between witnessing domestic violence and alcohol use/abuse, with respondents who reported domestic violence being more likely to report alcohol use/abuse than those who did not report witnessing domestic violence (for both females and males as reported in Simantov et al. 2000 cited in Tonmyr et al. 2010-). Hamburger et al. (2008 cited in Tonmyr et al. 2010-) found that the association was significant, while Simantov et al. (2000 cited in Tonmyr et al. 2010-) found that the association was significant in females but not in males. The reported odds ratios for significant associations ranged between 1.4 (95% CI 1.1 to 2.0) and 1.9 (95% CI 1.6 to 2.2).

Cigarette use

In Tonmyr et al. (2010 -), 8 studies reported on the association between physical abuse and cigarette use (Acierno et al. 2000; Fergusson et al. 1997; Frederikson et al. 2008; Hibbard et al. 1988; Lau et al. 2003; Moran et al. 2004; Perkins and Jones 2004; Riggs et al. 1990, cited in Tonmyr et al. 2010 -). All 8 studies found a significant association between physical abuse and cigarette use/abuse, with respondents who reported physical abuse being significantly more likely than those who did not report physical abuse to report cigarette use/abuse. Both Acierno et al. (2000 cited in Tonmyr et al. 2010-) and Frederikson et al. (2008 cited in Tonmyr et al. 2010-) found this to be the case in males and females; and Lau et al. (2003 cited in Tonmyr et al. 2010-) found that this was the case using 2 different measures. Six studies reported odds/relative risk ratios, which ranged between 1.8 (95% CI not reported) and 6.1 (95% CI 2.7 to 13.7).

Eleven studies examined the association between sexual abuse and cigarette use, with 10 studies finding a statistically significant relationship (Acierno et al. 2000; Bergen et al. 2004; Chandy et al. 1997; Choquet et al. 1997; Hernandez et al. 1992; Hibbard et al. 1988; Howard et al. 2005; Moran et al. 2004; Nelson et al. 1994; Watts and Ellis 1993, cited in Tonmyr et al. 2010 -). Four of the studies found a significant association reported odds/relative risk ratios which ranged between 2.0 (95% CI 1.6 to 2.5) and 4.2 (95% CI not reported). One study reported a non-significant association between sexual abuse and cigarette use/abuse (Riggs et al. 1990, cited in Tonmyr et al. 2010 -). This study found a relationship in the reverse direction,

meaning that participants who had experienced sexual abuse were less likely to report cigarette use/abuse (odds ratio 0.9, 95% CI 0.4 to 2.4). The review authors suggest that this may be due to resilience or the result of protective factors such as foster care placement, extra-curricular activities, and so on.

There was 1 study which reported on the association between emotional abuse and cigarette use/abuse (Moran et al. 2004, cited in Tonmyr et al. 2010 -). The study found that there was a significant association between emotional abuse and cigarette use, with respondents who reported emotional abuse being significantly more likely than those who did not report emotional abuse to report cigarette use/abuse (odds ratio 1.4, reported by review authors as significant but 95% CI is not reported).

One study reported on the association between witnessing domestic violence and cigarette use/abuse (Simantov et al. 2000 cited in Tonmyr et al. 2010-). The study found an association between witnessing domestic violence and cigarette use/abuse, with both female and male respondents who reported witnessing domestic violence being more likely to report cigarette use/abuse than those who did not report witnessing domestic violence. However, this association was not statistically significant in males (1.4 relative risk ratio (95% CI 0.9 to 2.2), but it was found to be significant in females (relative risk ratio 2.2 95% CI 1.6 to 3.2).

No studies examined the relationship between neglect and cigarette use.

5. Suicidal behaviour in children and young people

We found 4 moderate quality systematic reviews of the association between maltreatment and suicidal behaviour (Evans et al. 2005 +; Miller et al. 2013 +; Mironova et al. 2011 +; Rhodes et al. 2011 +), covering a total of 80 studies. There was some overlap between the systematic reviews, with 11 studies appearing in 2 systematic reviews (Anteghini et al. 2001; Bagley et al. 1995; Bensley et al. 1999; Brezo et al. 2008; Buddeberg et al. 1996; Eisenberg et al. 2007; Fergusson et al. 1996; Garnefski and Arends 1998; Grossman et al. 1991; Martin et al. 2004; Rosenberg et al. 2005), and 1 appearing in 3 (Wagman Borowsky et al. 1999).

We found 1 moderate quality UK systematic review (Evans et al. 2005 +) of the association between abuse and ‘suicidal phenomena’, including suicidal ideation,

suicidal thoughts and plans, and suicide attempts in adolescents, which included 9 studies. The review did not undertake a meta-analysis or calculate pooled odds ratios for the studies – the authors did not discuss reasons for this. Studies included in the review were from the USA (5 studies), Switzerland (2 studies), France (1 study) and New Zealand (1 study). Studies were included in which the majority of participants (90% of more) were aged 12 to 20. This means that 2 studies (Rey Gex et al. 1998; Wagman Borowsky et al. 1999) have some participants which are out of the age range of this review (>18). However, due to the quality of the systematic review, and the fact that the majority of participants in the studies met our criteria, a decision was taken to include this review.

Four studies examined the association between physical abuse and suicidal phenomena. Three of the 4 studies (Grossman et al. 1991; Jones 1992; Wagman Borowsky et al. 1999, cited in Evans et al 2005 +) found a statistically significant relationship between physical abuse and suicidal phenomena. Two of these studies reported odds ratios, the lowest being 1.9 (95% CI 1.5 to 2.4), and the highest 3.5 (95% CI 3.1 to 4.1). One study found higher odds ratios for females (3.5, 95% confidence interval 3.1 to 4.1) compared to males (3.26 95% confidence interval 2.61 to 4.07) (Wagman Borowsky et al. 1999, cited in Evans et al 2005 +). A second study (Jones et al. 1992, cited in Evans et al 2005 +) found a significant association between frequency of being hit and rates of suicidal thoughts and plans (chi-square =78.96, $p<0.0001$), and rates of suicide attempt (chi-square =111.16, $p<0.0001$). One study (Wright 1985) found a non-significant association between physical abuse and suicidal phenomena.

Five studies (reported in 6 papers) examined the association between sexual abuse and suicidal phenomena (Bensley et al. 1999; Buddeberg et al. 1996; Fergusson et al. 1996; Grossman et al. 1991; Rey Gex et al. 1998, Wagman Borowsky et al. 1999, cited in Evans et al 2005 +). All 5 studies found that adolescents reporting a history of sexual abuse were more likely to report a history of suicidal phenomena. Three studies reported odds ratios, which ranged from 1.5 (95% confidence interval 1.2 to 1.9) to 47.1 (95% confidence interval 23.2 to 95.3). One study (Bensley et al. 1999, cited in Evans et al 2005 +) found that the size of the effect was greater depending

on the seriousness of the abuse, that is, whether the abuse was defined as ‘molestation’ or ‘sexual abuse’.

A second moderate quality systematic review (Rhodes et al. 2011 +) reviewed 16 studies reported across 17 papers examining sex differences in the relationship between sexual abuse and suicide-related behaviours, including self-harm (no suicidal intent), suicide-related behaviour with undetermined intent and suicide attempt, among 12-18-year-olds. Included studies were conducted in the USA (7 studies), the UK (2 studies), Australia (2 studies), France (1 study), Canada (1 study), Brazil (1 study), South Africa (1 study) and Sweden (1 study).

Eight studies provided unadjusted data on the association between sexual abuse and suicide attempts (Ackard and Newmark-Sztainer 2003; Anteghini et al. 2001; Eisenberg et al. 2007; Howard and Wang 2005; Martin et al. 2004; Olshen et al. 2007; Rosenberg et al. 2005; Wagman Borowsky et al. 1999 cited in Rhodes et al. 2011 +). There was a positive, statistically significant association between sexual abuse and suicide attempts in all 8 studies. Odds ratios were higher for boys than girls in all studies except for 1 (Rosenberg et al. 2005 cited in Rhodes et al. 2011 +). Unadjusted odds ratios for girls ranged from 2.2 (95% CI 1.4 to 3.4) to 5.1 (95% CI 2.5 to 10.4), and unadjusted odds ratios ranging from 4.5 (95% CI 3.3 to 6.1) to 30.8 (95% CI 12.0 to 78.6) for boys.

Ten studies reported in 11 papers provided adjusted results for the association between sexual abuse and suicide attempts (Anteghini et al. 2001; Bergen et al. 2003; Choquet et al. 1997; Eisenberg et al. 2007; Garnefski and Arends 1998; Gold 1996; Howard and Wang 2005; King et al. 2004; Martin et al. 2004; Olshen et al. 2007, Wagman Borowsky et al. 1999, cited in Rhodes et al. 2011 +), although not all of these reported results in full. Studies adjusted for a range of factors hypothesised to mediate the CSA-suicide association, including ethnicity, family living arrangements, drug use, self-image, being bullied, uncertainty over sexual orientation and so on. Each of these studies found an association between childhood sexual abuse and suicide attempt(s) in girls; however this association was only found to be significant by 5 studies. All 10 of the studies also found an association between childhood sexual abuse and suicide attempt(s) in boys; however this association was only found to be significant by 9 studies. For 6 studies reporting both unadjusted and

adjusted results, in 4 the adjusted association remained statistically significant in boys but not girls (Anteghini et al. 2001; Howard and Wang 2005; Martin et al. 2004; Olshen et al. 2007, cited in Rhodes et al. 2011 +). In the remaining 2 (Eisenberg et al. 2007; Wagman Borowsky et al. 1999, cited in Rhodes et al. 2011 +), the associations remained significant, with the magnitude of the association greater for boys than girls. The reported adjusted odds ratios for girls ranged between 1.1 (95% CI 0.8 to 1.7) and 6.8 (95% CI 4.5 to 10.2 95% CI). The reported adjusted odds ratios for boys ranged between 1.9 (95% CI 1.1 to 3.2) and 27.8 (95% CI 9.8 to 78.9).

In the Rhodes et al. (2011 +) systematic review, 5 studies reported across 6 papers examined the association between sexual abuse and suicide-related phenomena (e.g. self-harm) where the intent was unknown (Bagley et al. 1995; Bergen et al. 2003/Martin et al. 2004; Edgardh and Ormstad 2000; Hawton et al. 2002; O'Connor et al. 2009 cited in Rhodes et al. 2011 +). For the unadjusted data, all studies found a statistically significant association between abuse and suicide-related behaviours in both boys and girls, with reported odds ratios for girls ranging from 3.3 (95% CI 1.8 to 5.5) to 4.1 (95% CI 3.0 to 5.6) and odds ratios for boys ranging from 2.9 (95% CI 2.9 to 19.2) to 10.3 (95% CI 4.0 to 26.0). After controlling for variables such as depression, family functioning and drug use the 4 studies reporting adjusted results (Bergen et al. 2003/Martin et al. 2004; Edgardh and Ormstad 2000; Hawton et al. 2002; O'Connor et al. 2009, cited in Rhodes et al. 2011+) found that none of the associations between abuse and suicide-related behaviours in girls was statistically significant, and only 1 study found a statistically association in boys. No reported adjusted odds ratios for girls were reported, 1 adjusted odds ratio (for significant result) for boys was reported: 4.3 (95% CI 1.5 to 12.6).

A third moderate-quality systematic review (Mironova et al. 2011 +), conducted in Canada, examined the association between child physical abuse where the perpetrator is identified as a family member or parent, and suicide-related behaviours (suicide attempts) in young people under 18. The review includes 5 studies, conducted in the USA (1 study), South Africa (1 study), Hong Kong (1 study), New Zealand (1 study) and Canada (1 study). Child physical abuse was defined as the 'intentional use of physical force against a child that results in, or has

the potential to result in, physical injury' (p2). Four studies used self-report data of suicide-related behaviour, and 1 combined self- and parent-report data.

Unadjusted data from all 5 studies (Brezo et al. 2008; Fergusson and Lynskey 1997; Flisher et al. 1996; Lau et al. 2003; Logan et al. 2009, cited in Mironova et al. 2011 +) found statistically significant associations between physical abuse perpetrated by a family member and suicide-related behaviours. Three studies reported unadjusted odds ratios/prevalence ratios, which ranged from 1.8 (95% CI 1.1 to 3.9) to 3.7 (95% CI not reported). Three studies reported adjusted odds ratios/prevalence ratios, after controlling for factors such as age, race and family violence, which ranged from 1.9 (95% CI 1.0 to 3.6) to 2.5 (95% CI 1.9 to 3.3). One of the included studies (Fergusson and Lynskey 1997, cited in Mironova et al. 2011 +) found that rates of suicide attempt increased depending on the severity of physical punishment (adjusted significance level, $p<0.05$; no odds ratios reported). One study (Brezo et al. 2008, cited in Mironova et al. 2011 +) also examined the relationship between a combination of physical abuse and sexual abuse and suicide-related behaviours, estimating an adjusted odds ratio of 4.7 (95% CI 2.5-8.9).

A fourth moderate-quality systematic review (Miller et al. 2013 +) conducted a narrative review of 52 studies (no statistical data reported). Included studies were conducted in the USA (13 studies), New Zealand (4 studies), Switzerland (2 studies), Canada (2 studies), Brazil (1 study), the Netherlands (1 study), Italy (1 study), Australia (1 study), France (1 study) and country not reported (26 studies). The review examines the association between sexual abuse, physical abuse, emotional abuse and neglect; co-occurring sexual and physical abuse; and maltreatment in general, with suicide attempts and ideation in young people aged 12 to 17. The authors synthesise results in terms of numbers of studies showing particular results, based on 2 data tables appended to the report, but it is difficult to ascertain exactly which studies have contributed to which findings.

Fifty-two studies examined the association between sexual abuse and suicide ideation and/or attempts. Forty-nine found an association between history of sexual abuse and increased suicidal ideation and/or suicide attempts. No statistical data or odds ratios are reported. The association between sexual abuse and suicidal behaviour/ideation remains significant when controlling for demographic variables of

age and grade level (11 studies); sex (8 studies), IQ (1 study) and race/ethnicity (4 studies); youth mental health problems (7 studies); general psychiatric symptoms during childhood and early adolescence (1 study); family structure (2 studies); parental separation (1 study); mothers' level of education (1 study); family socioeconomic status (4 studies); parental violence or imprisonment (1 study); parenting style or family functioning (3 studies); parents' psychiatric symptoms and substance abuse (3 studies); and parental suicide (1 study). The association is not clear when controlling for negative life events. There is some evidence that accumulative negative life events may affect the relationship between sexual abuse and suicidal ideation/suicide attempts.

Similarly, of the 34 studies exploring the link between physical abuse, 30 found an association (no statistical data or odds ratios reported). Six cross-sectional studies exploring the link between emotional abuse and neglect and suicidal behaviour found significant relationships (no statistical data or odds ratios reported). However, a 17-year longitudinal study (Brown et al. 1999, cited in Miller et al. 2013 +) found that childhood neglect did not predict future suicidal behaviour.

When sexual abuse and physical abuse were examined simultaneously, only sexual abuse was associated with various measures of suicidal ideation and behaviour (4 studies), after controlling for socioeconomic status (2 studies), youth dissociative symptoms (1 study), youth negative life events (1 study), parental violence, parental mental health symptoms, parental imprisonment (1 study), mother's education, parenting etc. (1 study). There was an additive effect of sexual and physical abuse on suicide attempts (3 studies). Youth victims of both forms of abuse were more likely to report suicide attempts (3 studies) than either alone, as well those with no abuse (1 study), both in any suicide attempt (3 studies) as well as multiple attempts (1 study), the latter only found for females. One study showed an additive effect of both forms of abuse on suicidal ideation, and 1 study did not.

The review undertook a multivariate analysis of the relative contribution of each form of child maltreatment (sexual abuse, physical abuse, emotional abuse and neglect) to adolescent suicidal ideation and behaviour. Thirteen studies examined this relationship. All forms of abuse were independently associated with suicide attempts (5 studies) and/or suicidal ideation (2 studies). When controlled for contextual risk

factors (sex, ethnicity, IQ, temperament, serious mental illness, anger, dissatisfaction, external locus of control, sociopathy, low religious participation, teenage pregnancy, single parenthood, welfare support, low family income, large family size, maternal factors, paternal factors), only sexual and physical abuse, not neglect, remained significant (1 study).

6. Language development and ability

Description of evidence

We were unable to find an existing systematic review of the relationship between experience of maltreatment and language ability and development. We therefore undertook a search within our database of studies relating to language (see Appendix A for further details). This resulted in 13 potential studies. The full text of these was reviewed, and 9 were selected for data extraction.

The studies comprised 1 moderate quality US prospective cohort study (Noll et al. 2010 +) and 8 observational comparative studies, broadly comparing abused with non-abused children at a single time point. Of these, 5 were moderate quality US studies (De Bellis et al. 2009 +; Eigsti and Cicchetti 2004 +; Pears and Fisher 2005 +; Prasad et al. 2005 +; Spratt et al. 2012), 1 was a moderate quality UK study (Kocovska et al. 2012 +), 1 was a poor quality US study (Gilbert et al. 2013 -) and 1 was a poor quality Canadian study (Nolin and Ethier 2007 -).

Several of the studies measured a variety of outcomes relating to children's development – this review focused solely on outcomes relating to language. The characteristics and findings of the studies are summarised in the table below.

Table 1. Summary of papers relating to language

Paper and quality rating	Country	Sample size	Age of children	Type(s) of abuse	Measure(s) of language	Findings
De Bellis et al. (2009) +	US	106	7-13	Neglect and PTSD Neglect without PTSD Non-neglected control	NEPSY PPVT	Significant difference between neglected children and non-neglected children on: Overall language, medium effect size ($p<0.001$, partial eta squared =0.16). NEPSY speeded naming, small to medium effect size ($p<0.01$, partial eta squared =0.12) NEPSY comprehension, small to medium effect size ($p<0.05$, partial eta-squared =0.09), PPVT, small to medium effect size ($p<0.05$, partial eta-squared =0.12). No significant difference on NEPSY phonological ($p>0.05$, partial eta squared=0.01).
Eigsti and Cicchetti (2004) +	US	33	4-5	Chronic maltreatment (n=19) Non-maltreated control (n=14)	Index of productive syntax Auxiliary verbs PPVT-R	Maltreated group had significantly lower scores than the comparison group on measures of syntactic complexity ($p=.03$, effect sizes not reported or calculable) and on measures of receptive vocabulary, with medium to large effect size ($p<.04$. ES=-0.78). Marginally significant difference between the groups on production of auxiliary verbs in obligatory contexts ($p<0.10$, effect size not reported or calculable).

Gilbert et al. (2013) -	US	16,595	Under 6	Exposure to domestic abuse Non-maltreated control	Missing developmental milestones	For parents who self-reported intimate partner violence and parental psychological distress, increased risk of their child missing developmental milestones in language development (adjusted OR=2.1, 95% CI 1.3 to 3.3). For parents reporting intimate partner violence only, also an increased risk of their child missing developmental milestones in language development (adjusted OR=1.4, 95% CI 1.1 to 1.9).
Kocovska et al. (2012) +	UK	66	5-12	Severe maltreatment leading to adoption Non-maltreated control	WAIS Renfrew language scales	Children in the adopted group had significantly lower scores of verbal intelligence than children in the comparison group (t=-3.41; p=.001), with large effect size (ES=-1.14). The authors also report significantly lower scores of verbal-performance intelligence (t=0.73; p=.001). However, this result appears to be in error.
Nolin and Ethier (2007) -	Canada	137	6-12	Neglect with physical abuse Neglect without physical abuse Non-neglected control	Comprehension of instructions	No significant differences between the groups on the Comprehension of Instructions test of receptive language (p=0.173, ES=0.020).
Noll et al. (2010) +	US	186	Up to 18	Sexual abuse Non-maltreated control	PPVT (receptive language)	The study found that there was an overall difference in the overall rate of development of language in abused females compared to a non-abused comparison group, (p=0.008). Post hoc testing showed that significant differences between the groups were observable between the ages of 15 and 18 (p<0.007), but not in childhood (p>0.007) or young/mid-adolescence (p>0.007). It

						was not possible to calculate effect sizes using the data available.
Pears and Fisher (2005) +	US	153	3 to 6	Foster care following maltreatment Non-maltreated control	NEPSY Preschool language scale	Significant difference in language ability, with children in foster care showing significantly lower ability than a community comparison, with medium to large effect size (p=0.000, ES=-0.78).
Prasad et al. (2005) +	US	38	1 to 6	Physical abuse resulting in hospitalisation Non-maltreated control	Sequenced Inventory of Communication Development Clinical Evaluation of Language Fundamentals	Children who had experienced physical abuse showed significantly poorer receptive language skills with large effect size (p=0.004, ES=-1.00). They also showed significantly poorer expressive language skills with large effect size (p=0.0007, ES=-1.23).
Spratt et al. (2012) +	US	60	3 to 10	History of familial neglect or institutional neglect	TELD receptive TELD expressive TELD overall	Significant difference between the groups on the TELD receptive measure (p<0.0001), TELD expressive measure (p=0.0001) TELD oral composite measure (p<0.0001). Post hoc tests showed that the control group performed significantly better than the US neglected group and the internationally adopted group in each case. It is not clear whether there was a difference between the US neglect and internationally adopted groups.

Summary

Four studies found significant differences between abused and non-abused children on all employed measures of language ability/development.

Gilbert et al. (2013 -) examined health records for 16,595 children to investigate the association between child exposure to intimate partner violence and parental psychological distress, and attainment of developmental milestones, including in relation to language. The study was rated as poor quality because:

- classification of exposure to parental intimate partner violence was based on parental self-report, which may have led to under-reporting
- a high proportion of study participants were Spanish speaking (21.5%), but it is unclear whether there was an option to assess child linguistic milestones in Spanish
- the study describes itself as 'cross-sectional' but appears to have included data from the same children at multiple time points; the impact of this on regression estimates is not discussed.

The study found that, for parents who self-reported intimate partner violence and parental psychological distress, there was an increased risk of their child missing developmental milestones in language development (adjusted OR=2.1, 95% CI 1.3 to 3.3). For parents reporting intimate partner violence only, there was also an increased risk of their child missing developmental milestones in language development (adjusted OR=1.4, 95% CI 1.1 to 1.9).

Pears and Fisher (2005 +) conducted a comparative study with 153 participants examining the association between maltreatment and a range of cognitive and neuropsychological functions. Data were extracted here for measures of language ability only.

The study found that there was a significant difference in language ability, with children in foster care showing significantly lower ability than a community comparison, with medium to large effect size ($p<0.001$, ES=-0.78).

Among maltreated children, there was a significant correlation between the presence of neglect or emotional abuse and poorer language ability, with small to medium effect size ($r=-0.22$, $p<0.05$). There was a significant positive association between the number of maltreatment types children had experienced, and better language ability, with small to medium effect size ($r=0.23$, $p<0.05$). The direction of this relationship is surprising – the authors hypothesise that this may be because children who have experienced more types of abuse come to the attention of authorities earlier and are so more likely to receive services.

Prasad et al. (2005 +) conducted a comparative study with 38 participants aged from 14 to 77 months (19 who had experienced physical abuse and 19 matched controls). They found that children who had experienced physical abuse showed significantly poorer receptive language skills with large effect size ($p=0.004$, ES=-1.00). They also showed significantly poorer expressive language skills with large effect size ($p=0.0007$, ES=-1.23). However, it should be noted that the children in the physical abuse group were identified following hospitalisation for physical abuse, and are therefore likely to represent the more severe end of the spectrum of physical abuse. The sample size for the study is also relatively small.

Spratt et al. (2012 +) undertook an observational comparative study with 60 participants, comparing cognitive, language and behavioural functioning in children aged 3 to 10 years with a history of familial neglect, a history of living in an overseas institution, and a control group. Only data in relation to language have been reported here.

The study found that there was a significant difference between the groups on the Test of Early Language Development (TELD) receptive measure ($p<0.0001$), TELD expressive measure ($p=0.0001$) and TELD oral composite measure ($p<0.0001$). Post hoc tests showed that the control group performed significantly better than the US neglected group and the internationally adopted group in each case. It is not clear whether there was a difference between the US neglect and internationally adopted groups. It was not possible to calculate effect sizes from the available data.

Four studies found significant differences on some measures of language ability but not others. De Bellis et al. (2009 +) undertook a cross-sectional study with 106 child

participants aged between 7 and 13 who had experienced neglect and PTSD (n=22), neglect without PTSD (n=39) and non-neglected controls (n=45). Neglect was determined via Department of Social Services records. Language ability was assessed using the NEPSY scale (neuropsychological battery) (Korkman et al. 2001) and the Peabody Picture Vocabulary Test (Dunn et al. 1997).

The study found that neglected children (both with and without PTSD) showed significantly lower overall language ability compared to the non-neglected control group with medium effect size when not controlling for child IQ ($p<0.001$, partial eta squared =0.16). When controlling for child IQ this reduced to small to medium effect size ($p<0.01$, partial eta squared =0.12). When controlling for IQ, significant differences were observed on the NEPSY speeded naming, with small to medium effect size ($p<0.05$, partial eta-squared =0.09), NEPSY comprehension, with small to medium effect size ($p<0.05$, partial eta-squared =0.09) and Peabody Picture Vocabulary Tests, with small to medium effect size ($p<0.05$, partial eta-squared =0.12). However, no significant differences were observed on the NEPSY phonological processing measure ($p>0.05$, partial eta squared =0.01). There were no significant differences between neglected children with versus those without PTSD.

Eigsti and Cicchetti (2004 +) conducted a cross-sectional study with 106 participants aged between 4 and 5 who had experienced chronic maltreatment (n=19) and a non-maltreated comparison (n=14). Children in the maltreated group had experienced emotional abuse (16/19), neglect (9/19), physical abuse (10/19), and physical abuse and neglect (9/19).

Language ability was measured using the Index of Productive Syntax (Scarborough 1990), an assessment of the production of auxiliary verbs in obligatory contexts, and the Peabody Picture Vocabulary Test – Revised (Dunn and Dunn 1981). The maltreated group had significantly lower scores than the comparison group on measures of syntactic complexity ($p=.03$, effect sizes not reported or calculable) and on measures of receptive vocabulary, with medium to large effect size ($p<.04$. ES=-0.78). However, there was only a marginally significant difference between the groups on production of auxiliary verbs in obligatory contexts ($p<0.10$, effect size not reported or calculable). However, it should be noted that this did not appear to be a validated measure.

Noll et al. (2010 +) conducted a prospective cross-sequential study with 186 female participants (84 who had experienced substantiated sexual abuse, and 102 comparison participants). The study measured receptive language ability at 6 time points across 18 years. Only data gathered up to the age of 18 are reported here.

The study found that there was an overall difference in the rate of development of language in abused females compared to a non-abused comparison group ($p=0.008$). Post hoc testing, using a corrected significance criterion of $p=0.007$, showed that significant differences between the groups were observable between the ages of 15 and 18 ($p<0.007$), but not in childhood ($p>0.007$) or young/mid-adolescence ($p>0.007$). It was not possible to calculate effect sizes using the data available.

For 1 study, it was unclear whether all results were significant. Kocovska et al. (2012 +) undertook an observational comparative study with 66 child participants aged between 5 and 12. The study compared a group of adopted children (n=34) who had experienced severe maltreatment at an early age and showed symptoms of indiscriminate friendliness to a group of non-adopted 'typically developing' controls matched on age and gender (n=32).

Experience of maltreatment was determined by extracting information from social worker notes of using a checklist designed specifically for the study. Although data in relation to a number of different recognition indicators have been extracted, only those relating to language ability are reported here. Analysis of between group differences in this data was conducted using t-tests and Fisher's exact test.

Language ability, narrative speech and short term-memory were tested using the Renfrew Language Scales – Bus Story Test, and the researchers found that the number of children in the adopted group performing below their chronological age on this test was significantly higher than the number in the comparison group ($p=0.001$). The number of children in the adopted group whose language difficulties were deemed to 'merit' full assessment was also significantly higher than the number in the comparison group ($p=0.002$).

Verbal intelligence and verbal-performance intelligence were tested using the Wechsler Abbreviated Scale of Intelligence (exact subscales used unclear). The

researchers found that children in the adopted group had significantly lower scores of verbal intelligence than children in the comparison group (t=-3.41; p=.001), with large effect size (ES=-1.14). The authors also report significantly lower scores of verbal-performance intelligence (t=0.73; p=0.001). However, this result appears to be in error, and is inconsistent with the means and standard deviation error reported.

One poor quality study found no significant difference in the language abilities of abused compared to non-abused children. Nolin and Ethier (2007 -) undertook an observational study of 137 participants aged 6 to 12 and investigated the relationship between experiencing neglect with and without and physical abuse on cognitive functioning. The study compared children who had experienced neglect and physical abuse (n=56), children who had experienced neglect without physical abuse (n=28) and a matched control group (n=53). Only data relating to language were extracted here. This study was rated as poor due to concerns about validity of the outcome measure: only receptive, and not productive, language abilities were assessed. The study also had a relatively small sample size, particularly for the neglect without physical abuse subgroup. The study found no significant differences between the groups on the Comprehension of Instructions test of receptive language (p=0.173, ES=0.020). This measure also did not contribute to discriminant analysis between abused and non-abused children (no data reported).

Overall, across the studies examined there was a relatively consistent finding of association between previous experience of maltreatment and poorer language abilities, measured using a range of measures including validated measures such as the Peabody Picture Vocabulary Test, the Test of Early Language Development (TELD) and NEPSY, as well as on measures such as meeting ‘developmental milestones’. An association was observed for a range of forms of abuse including exposure to domestic violence, sexual abuse, neglect, physical abuse and emotional abuse. Effect sizes were not reported consistently across studies, and were not calculable for all studies where they were not reported. Effect sizes, where available, ranged from small to medium (partial eta-squared =0.12) to large (ES=-1.23).

One study (Noll et al. 2010 +) found that differences in language ability were observable between 15 and 18, but not before. This is in contrast to many of the other studies, which found significant associations between maltreatment and poorer

language ability in children of younger ages. However, this study related to sexual abuse, with median age of onset at 7.8 years, in contrast to many other studies where abuse had occurred at an earlier age.

Three studies (Kocovska et al. 2012 +; Pears and Fisher 2005 +; Spratt et al. 2012 +) found significant differences in language ability even when children who had experienced maltreatment were now in foster care or had been adopted.

7. Child drawings

Description of evidence

We found 1 poor quality systematic review of controlled studies comparing the drawings of abused versus non-abused children (Allen et al. 2012 -). Included studies were published between 1981 and 2007.

The quality of the included studies was largely poor due to small sample size, methodological weaknesses, poor reliability of ratings and confounders such as including comparison groups with mental illness. The authors report that where studies do have significant findings, these are rarely replicated, and conflicting evidence exists in many cases. Several included studies carried out high numbers of separate analyses, making a 'false positive' significant result more likely. The review itself was also rated as poor due to inconsistent reporting of statistical data from original studies.

Summary

This systematic review of controlled studies (n=23 studies, involving 1277 sexually abused and 474 physically abused children) examined whether any graphic indicators can reliability and validly discriminate abused from non-abused children. The authors examined data from studies utilising a variety of drawing methods, including human figure drawings, kinetic family drawings and 'favourite kind of day' drawings.

For sexually abused children, the evidence suggested that there was, overall, no significant difference between sexually abused children and controls in terms of the following.

- Drawing of genitalia (6 studies: Hibbard and Hartman 1990a, 1990b; Hibbard et al. 1987; Howe et al. 1987; Sidun and Rosenthal 1987; Yates et al. 1985), no effect sizes reported.
- Drawing of 'sexually related features' between sexually abused and control group (3 studies: Hibbard and Harman 1990a; Howe et al. 1987; Sidun and Rosenthal 1987), no effect sizes reported. One study (Sidun and Rosenthal 1987) did find a significant difference, but as they conducted numerous analyses this may be due to a type 1 error (false positive).
- Omission of, abnormal size, or poorly integrated body parts (3 studies: Hibbard and Hartman 1990a; Howe et al. 1987; Sidun and Rosenthal 1987), no effect sizes reported.
- Other graphic indicators such as shading, monsters, clouds, presence of teeth, slanting figure, small figure, big figure and the use of colour (3 studies: Hibbard and Hartman 1990a; Howe et al. 1987; Sidun and Rosenthal 1987).

Studies using 'kinetic family drawings' (Cohen and Phelps1985; Hackbarth et al. 1991; Piperno et al. 2007) were deemed too unreliable to support valid findings.

For physically abused children:

- The evidence did not suggest that omitting a bodily feature from a drawing distinguishes physically abused children from their non-abused peers (3 studies: Blain et al. 1981; Culbertson and Revel 1987; Prino and Peyrot 1994).
- Drawings with poor body integration or asymmetry of limbs were unlikely to be indicative of physical abuse (4 studies: Blain et al. 1981; Culbertson and Revel 1987; Hjorth and Harway 1981; Prino and Peyrot 1994).
- No evidence was found to suggest that any of the following are present more often in the drawings of physically abused children: clouds, fruit on trees, person composed of geometric shapes, unusually large figures, environmental objects, and the use of colour (4 studies: Blain et al. 1981; Culbertson and Revel 1987; Hjorth and Harway 1981; Howe et al. 1987).

Part B – Risk factors relating to children and young people

1. Child disability as a risk factor

Description of evidence

We found 3 systematic reviews providing information on the association between child disability and maltreatment. Two reviews focused solely on the relationship between child disability and occurrence of maltreatment, 1 was a good quality review (Govindshenoy et al. 2006 ++) and 1 was a moderate quality meta-analysis (Jones et al. 2012 +). One study was a poor quality meta-analysis (Stith et al. 2009 -) exploring a range of risk factors for child abuse and neglect, including child disability.

Jones et al. (2012 +) conducted a meta-analysis of 11 studies, 10 cross-sectional and 1 cohort (Alriksson-Schmidt et al. 2010; Blum et al. 2001; Cuevas et al. 2009; Dawkins 1996; Everett Jones et al. 2008; Miller 1996; Reiter et al. 2007; Spencer et al. 2005; Sullivan et al. 2000; Suris et al. 1996; Verdugo et al. 1995, cited in Jones et al. 2012 +) which covered a total of 13,505 participants. It was not reported in which countries the studies were conducted. The reviewing team were based in the UK.

The meta-analysis examined risk of maltreatment according to type of disability ('any disability' and 'mental or intellectual disability') and for different types of violence (physical, sexual, emotional, neglect and 'any maltreatment' – measures comprising 1 or more types of maltreatment). Limited data were available regarding the individual studies included in this meta-analysis – we requested from the author an appendix cited in the report, but received no response. Brief investigation of some of the included studies suggested that their definition of 'abuse' may have been relatively broad, for example including issues such as bullying by peers. If this were the case, risk estimates may be inflated. The authors also conducted meta-analysis despite substantial heterogeneity between studies – this heterogeneity is commented upon by the authors, but does mean that some caution is required when interpreting results.

Govindshenoy et al. (2006 ++) reviewed 4 population-based studies (2 longitudinal studies, 1 retrospective birth cohort study, and 1 cross-sectional survey) examining the association between disability and experience of abuse or neglect in childhood (Brown et al. 1998; Sidebotham and Heron 2003; Spencer et al. 2005; Vizcarra et al.

2001). Two of the included studies were UK studies, 1 was from the USA and 1 from Chile. The reviewing team were based in the UK. The odds ratios of individual studies are reported separately and meta-analysis was not conducted due to heterogeneity. Where odds ratios were not provided by the individual study these were calculated by the review authors if the data required were available.

Stith et al. (2009 -) reviewed 4 studies of the association between child disability and physical abuse (Crittenden 1988; Lau and Donnan 1987; Perry et al. 1983; Starr 1982). No information is provided regarding types of disability included in those studies.

One primary study – a large (n=119,729) retrospective UK birth cohort study (Spencer et al. 2005) was included in more than 1 review (Govindshenoy et al. 2006++; Jones et al. 2012 ++).

Narrative summary

All/unspecified forms of disability

The meta-analysis by Jones et al. (2012 +) found that, overall, children with any kind of disability were at significantly increased risk of 'any' type of violence/maltreatment (measures which combined more than 1 form of abuse) (OR=3.68; 95% CI 2.56 to 5.29) (see Table 2). The meta-analysis also found that children with any type of disability were at significantly increased risk of physical violence (OR=3.56; 95% CI, 2.80 to 4.52). Exclusion of 2 outliers from this analysis (Reiter et al. 2007, as well as data relating to children with vision or hearing impairments reported by Spencer et al. 2005) resulted in a larger pooled odds ratio of 4.05, which was also significant (95% CI 3.39 to 4.82). It is not clear why these data were considered to be outliers.

The meta-analysis by Jones et al. (2012 +) further found that children with any disability were at significantly increased risk of sexual violence (OR=2.88; 95% CI 2.24 to 3.69); emotional abuse, (OR=4.36; 95% CI 2.42 to 7.87) and neglect (OR=4.56, 95% CI 3.23 to 6.43).

These findings are largely supported by the findings of Govindshenoy et al. (2006 ++) (see Table 3) who found significant associations between a range of types of disability and overall risk of maltreatment (conduct disorder, psychological disorders,

speech/language disorder, learning difficulty, developmental concerns). However, Govindshenoy et al. (2006 ++) report that this relationship did not hold for certain types of disability. For example, they report that the Spencer et al. (2005) study found that, after adjusting for adjusting for birthweight, gestational age, maternal age and socioeconomic status, there was no significant relationship between cerebral palsy and abuse (OR=1.79; 95% CI 0.96 to 3.35). They further report that Spencer et al. (2005) found no significant association between sensory disorders and overall risk of abuse (OR=0.76; 95% CI 0.31 to 1.83) or physical abuse specifically (OR=0.44; 95% CI 0.06 to 3.13), or between autism and overall risk of abuse (OR= 0.79; 95% CI 0.29 to 2.13) or physical abuse specifically (OR=1.23, 95% CI 0.31 to 5.05).

The meta-analysis by Stith et al. (2009 -) contradicts both other reviews, and finds a non-significant association between child disability and physical abuse (r=0.01, p>0.05). It is unclear what forms of disability were examined in the included studies. The discrepancy between the findings of this review and those of the others may be explained by the fact that the combined sample size of the 4 studies reviewed is much lower (n=325) compared to the total sample sizes for Jones et al. and Govindshenoy et al.

Table 2. Summary of odds ratios in Jones et al. (2012 +)

	Any maltreatment Odds ratio (95% CI)	Physical violence Odds ratio (95% CI)	Sexual violence Odds ratio (95% CI)	Emotional abuse Odds ratio (95% CI)	Neglect Odds ratio (95% CI)
Any disability	3.68 (2.56-5.29)	3.56 (2.80-4.52)	2.88 (2.24-3.69)	4.36 (2.42-7.87)	4.56 (3.23-6.43)
'Mental or intellectual disability'[4]	4.28 (2.12-8.62)	3.08 (2.08-4.57)	4.62 (2.08-10.23)	4.31 (1.37-13.56)	Insufficient sample

Table 3. Summary of findings in Govindshenoy et al. (2006 ++) review (non-significant findings are highlighted in grey)

Abuse type / Disability type	All/multiple forms of abuse	Physical abuse	Sexual abuse	Emotional abuse	Neglect
Cerebral palsy (Spencer et al. 2005)	Non-significant, adjusted[5] OR=1.79 (95% CI 0.96-3.35)	Significant association, OR=3.00 (95% CI 1.29-6.78)	No analyses possible – small n	No analyses possible – small n	Significant association, OR=2.71 (95% CI 1.08-6.80)
Conduct disorder (Spencer et al. 2005)	Significant association, adjusted OR=7.59 (95% CI 5.59-10.31)	Significant association, adjusted OR=4.09 (95% CI 2.22-7.54)	Significant association, adjusted OR=7.65 (95% CI 3.56-16.41)	Significant association, adjusted OR=11.58 (95% CI 7.72-17.37)	Significant association, adjusted OR= 8.22 (95% CI 4.76-14.18)
Non-conduct psychological disorders (Spencer et al. 2005)	Significant association, adjusted OR=4.38 (95% CI 2.61-7.36)	Significant association, adjusted OR=3.06 (95% CI 1.13-8.28)	Non-significant association, adjusted OR=1.99, 95% CI 0.28-14.28)	Significant association, adjusted OR=8.04 (95% CI 4.22-15.30)	Non-significant association, adjusted OR=2.73 (95% CI 0.87-8.62)

[4] Term used in paper.
[5] All odds ratios from Spencer et al. (2005) study adjusted for birthweight, gestational age, maternal age and socioeconomic status.

Learning disability

Jones et al. (2012 +) conducted a specific analysis of the association between what they term ‘mental and intellectual disability’ and maltreatment. The meta-analysis found that children with a mental or intellectual disability were found to be at significantly increased risk compared to non-disabled children of ‘any’ type of violence/maltreatment (measures which combined more than 1 form of abuse (OR=4.28; 95% CI 2.12-8.62). The odds ratio for this group was also higher than for children with ‘any disability’ (statistical significance of this difference not analysed).

Jones et al. (2012 +) also found that children with a mental or intellectual disability were found to be at significantly increased risk of sexual violence compared to non-disabled children (OR=4.62; 95% CI 2.08-10.23). The odds ratio for this group was also higher than for children with ‘any disability’ (statistical significance of this difference not analysed). Children with a mental or intellectual disability were also found to be at significantly increased risk of physical violence (OR=3.08, 95% CI 2.08-4.57) and emotional abuse (OR=4.31, 95% CI 1.37-13.56) compared to non-disabled children, however the risk was lower than for children with ‘any disability’ (statistical significance of this difference not analysed). Whereas, for all types of disability, the highest odds ratio was for increased likelihood of neglect and emotional abuse, for children with mental or intellectual disability, the highest odds ratio was for increased likelihood of sexual abuse.

The Govindshenoy review (Govindshenoy et al. 2006 ++) also found that after adjusting for birthweight, gestational age, maternal age and socioeconomic status, moderate/severe learning difficulty was associated with all forms of abuse combined (OR=4.69, 95% CI 3.75-5.86); physical abuse (OR=3.40, 95% CI 2.25-5.12); neglect (OR=5.34, 95% CI 3.68-7.23); emotional abuse (OR=2.93, 95% CI 1.88-4.57); and sexual abuse, (OR=6.38, 95% CI 3.81-10.68).

Other specific forms of disability

The Govindshenoy et al. (2006 ++) review also reported data in relation to a range of subtypes of disability, including cerebral palsy, conduct disorders, non-conduct psychological disorders, speech and language disorders, learning difficulty, sensory

disorders, autism, parent-reported development concerns, parent-reported emotional problems, parent-reported low verbal IQ, parental reports of the child being anxious or withdrawn and parent-reported presence of a handicap. The results of these analyses are presented in Table 3.

2. Other child risk factors

Description of evidence

We found 2 systematic reviews looking at the association between a range of child risk factors and abuse: 1 good quality (Hindley et al. 2015 ++) and 1 poor quality (Stith et al. 2009 -).

Stith et al. (2009 -) is a meta-analysis incorporating a total of 155 studies and examining 39 risk factors for physical abuse and neglect, of which 7 related to children. It is unclear in which countries the included studies were conducted. The reviewing team were based in the USA. The study is rated as poor firstly because of the poor quality of the search strategy for the review: only 1 database was searched, using keywords only without any free text search terms. A number of the analyses in the study also show high levels of heterogeneity across studies.

Hindley et al. (2015 ++) conducted a systematic review of 16 observational comparative studies published between 1979 and 2002. It is unclear in which countries the included studies were conducted. The reviewing team were based in the UK. This examined the factors that are associated with an increased risk of recurrence of maltreatment in children and families, including risk factors relating to the child.

Age of child

Stith et al. (2009 -) conducted a meta-analysis of 14 studies examining the relationship between child age and physical abuse, and 8 studies examining the relationship between child age and neglect. The authors conclude that there is a non-significant relationship between child age and either type of abuse ($r=-0.02$, $p>0.05$ and $r=-0.01$, $p>0.05$ respectively).

Hindley et al. (2015 ++) found 7 observational studies examining the impact of child age on risk of recurrence of maltreatment. Four of these found that younger children

were at greater likelihood recurrence of maltreatment (English et al. 1999; Fluke et al. 1999; Fryer and Miyoshi 1994; Herrenkohl et al. 1979). However, 3 further studies found no association between age and recurrence of maltreatment (Murphy et al. 1992; Rivara 1985; Swanston et al. 2002).

Gender of child

Stith et al. (2009 -) conducted a meta-analysis of 13 studies examining the relationship between child gender and physical abuse, and 5 studies examining the relationship between child age and neglect. The study concludes that there is a non-significant relationship between child gender and either type of abuse ($r=0.04$, $p>0.05$ and $r=0.01$, $p>0.05$ respectively), with neither girls nor boys more likely to be victims of these types of abuse.

Hindley et al. (2015 ++) examined 3 observational studies of the association between child gender and recurrence of maltreatment. No significant associations were found in any of the studies (Fryer and Miyoshi 1994; Rittner 2002; Swanston 2002, cited in Hindley et al. 2015 ++).

Internalising and externalising behaviours

Stith et al. (2009 -) conducted a meta-analysis of 31 studies looking at the association between child externalising behaviours and physical abuse, and 17 studies for neglect. It should be noted that the Stith et al. study has conceptualised externalising behaviour as a risk factor for abuse. However, other evidence we have reviewed has suggested that this can also be a consequence of abuse. The authors do not describe further how they have defined ‘externalising behaviour’: in some studies this is measured using the Child Behaviour Checklist or Parenting Stress Index.

A meta-analysis was also conducted of 23 studies looking at the association between child internalising behaviours and physical abuse, and 11 studies for neglect. Again, the authors conceptualise this as a risk factor for abuse, but it can also be a consequence of abuse.

The study found a significant positive association between externalising behaviour and physical abuse of small to medium effect size ($r=0.23$, $p<0.001$), and between externalising behaviour and neglect of small effect size ($r=0.11$, $p<0.001$).

The study also found a significant association between internalising behaviour and physical abuse of small effect size (r=0.15, p<0.001) and between internalising behaviour and neglect of small effect size (r=0.11, p<0.001).

Child social competence

Stith et al. (2009 -) conducted a meta-analysis of 14 studies looking at the association between child social competence and physical abuse, and 7 studies of the association between child social competence and neglect. Again, the authors conceptualise child social competence as a risk factor, but other studies we have reviewed have conceptualised this as a consequence of maltreatment.

The study found a significant negative association between child social competence and physical abuse with small to medium effect size (r=-0.26, p<0.001), but a significant positive association between child social competence and neglect with small effect size (r=0.11, p<0.001). The positive association is unexpected as it implies that as child social competence increases, the likelihood of neglect also increases. This is not commented on in the review.

Prenatal or neonatal problems

Stith et al. (2009 -) conducted a meta-analysis of 10 studies of the association between prenatal/neonatal problems and physical abuse. They found no studies examining the association between prenatal/neonatal problems and neglect. The study found that there was not a significant association between prenatal/neonatal problems and physical abuse (r=0.04, p>0.05).

Part C – Risk factors relating to parents

Description of evidence

We found 2 systematic reviews looking at the association between a range of child risk factors and abuse: 1 good quality (Hindley et al. 2015 ++) and 1 poor quality (Stith et al. 2009 -).

Stith et al. (2009 -) is a meta-analysis incorporating a total of 155 studies and examining 39 risk factors for physical abuse and neglect, of which 32 related to parents or the family. As noted above, the study is rated as poor firstly because of the poor quality of the search strategy for the review and due to

high levels of heterogeneity across studies. The results of the meta-analyses are shown in Table 4 (physical abuse) and

Table 5 (neglect). Medium to large and medium effect sizes are highlighted in yellow.

Hindley et al. (2015 ++) conducted a systematic review of 16 studies published between 1979 and 2002. This examined the factors that are associated with an increased risk of recurrence of maltreatment in children and families, including risk factors relating to the parent and family.

Table 4. Effect sizes for child physical abuse risk factors (taken from Stith et al. 2009 -)

Indicator	Number of studies	Effect size (r)	Significance (p)	Association	Size of effect	Ranking (highest effect size =1)
Parent–child interaction/parental report of child behaviour						
Parent perceives child as a problem	25	0.30	<0.001	Significant positive	Medium	4
Unplanned pregnancy	2	0.28	<0.001	Significant positive	Small to medium	6
Parent-child relationships	32	-0.27	<0.001	Significant negative	Small to medium	8
Parent use of corporal punishment	7	0.26	<0.001	Significant positive	Small to medium	10
Parenting behaviours	25	0.17	<0.001	Significant positive	Small	20
Stress over-parenting	11	0.07	<0.001	Significant positive	Small	32
Parent characteristics independent of the child						
Anger/hyper-reactivity	9	0.34	<0.001	Significant positive	Medium	2
Anxiety	8	0.29	<0.001	Significant positive	Small to medium	5
Psychopathology	13	0.28	<0.001	Significant positive	Small to medium	7
Parent depression	14	0.27	<0.001	Significant positive	Small to medium	9
Parent self-esteem	11	-0.24	<0.001	Significant negative	Small to medium	12
Poor relationship with own parents	11	0.22	<0.001	Significant positive	Small to medium	14
Parent experienced childhood abuse	15	0.21	<0.001	Significant positive	Small to medium	16
Parent criminal behaviours	4	0.21	<0.001	Significant positive	Small to medium	17
Personal stress	22	0.19	<0.001	Significant positive	Small	18
Social support	20	-0.18	<0.001	Significant negative	Small	19
Alcohol abuse	3	0.17	<0.001	Significant positive	Small	21
Unemployment	8	0.15	<0.001	Significant positive	Small	23

Parent coping/ problem-solving skills	4	-0.14	<0.05	Significant negative	Small	26
Single parenthood	22	0.12	<0.001	Significant positive	Small	28
Parent age	31	-0.10	<0.001	Significant negative	Small	30
Drug abuse	3	0.08	<0.05	Significant positive	Very small	31
Health problems	3	0.11	=ns	Non-significant	Small	29
Parent gender	2	0.07	<0.001	Significant positive	Very small	33
Approval of corporal punishment	5	0.05	=ns	Non-significant	Very small	34
Family characteristics						
Family conflict	5	0.39	<0.001	Significant positive	Medium	1
Family cohesion	5	-0.32	<0.001	Significant negative	Medium	3
Spousal violence	5	0.22	<0.001	Significant positive	Small to medium	15
Marital satisfaction	8	-0.16	<0.001	Significant negative	Small	22
Family size	23	0.15	<0.001	Significant positive	Small	25
Socioeconomic status	16	-0.14	<0.001	Significant negative	Small	27
Non-biological parent in the home	3	-0.03	=ns	Non-significant	Very small	35

Table 5. Effect sizes for child neglect risk factors (taken from Stith et al. 2009 -)

Indicator	Number of studies	Effect size (r)	Significance (p)	Association	Size of effect	Ranking (highest effect size =1)
Parent–child interaction/parental report of child behaviour						
Parent perceives child as a problem	4	0.41	<0.001	Significant positive	Medium to large	2
Unplanned pregnancy	No data					
Parent-child relationships	11	-0.48	<0.001	Significant negative	Medium to large	1
Parent use of corporal punishment	No data					
Parenting behaviours	8	0.18	<0.001	Significant positive	Small	12
Stress over-parenting	4	0.14	<0.01	Significant positive	Small	15
Anger/hyper reactivity	3	0.35	<0.001	Significant positive	Medium	4
Anxiety	No data					
Psychopathology	8	0.25	<0.001	Significant positive	Small to medium	7
Parent depression	8	0.21	<0.001	Significant positive	Small to medium	9
Parent self-esteem	4	-0.33	<0.001	Significant negative	Medium	5
Poor relationship with own parents	7	0.19	<0.001	Significant positive	Small	10
Parent experienced childhood abuse	6	0.15	<0.001	Significant positive	Small	14
Parent criminal behaviours	No data					
Personal stress	3	0.38	<0.001	Significant positive	Medium	3
Social support	13	-0.16	<0.001	Significant negative	Small	13
Alcohol abuse	No data					

Unemployment	4	0.25	<0.001	Significant positive	Small to medium	8
Parenting coping and problem-solving	No data					
Single parenthood	9	0.08	<0.001	Significant positive	Very small	16
Parent age	9	-0.12	<0.001	Significant negative	Small	17
Drug abuse	No data					
Health problems	No data					
Parent gender	No data					
Approval of corporal punishment	No data					
Family conflict	No data					
Family cohesion	No data					
Spousal violence	No data					
Marital satisfaction	No data					
Family size	12	0.26	<0.001	Significant positive	Small to medium	6
Socioeconomic status	10	-0.19	<0.001	Significant negative	Small	11
Non-biological parent in home	No data					

Summary

Parent-child interactions

Stith et al. (2009 -) examined 6 risk factors which they categorised as 'parent-child interactions': parent perceiving child as a problem, unplanned pregnancy, parent-child relationships, parent use of corporal punishment, parenting behaviours and stress over parenting. Some of these risk factors begin to 'overlap' with indicators of abuse (for example, parent-child relationships), however we will use the terminology of risk factors for consistency with the paper.

Significant positive associations were found for the following:

- Parent perceiving child a as a problem and physical abuse with medium effect size ($r=0.30$, $p<0.001$), and neglect with medium to large effect size ($r=0.41$, $p<0.001$).
- Unplanned pregnancy and physical abuse with small to medium effect size ($r=0.28$, $p<0.001$). No studies were found exploring the association between this variable and neglect.
- Parent use of corporal punishment and physical abuse with small to medium effect size ($r=0.26$, $p<0.001$). No studies were found exploring the association between this variable and neglect.
- Parenting behaviours and physical abuse, with small effect size ($r=0.17$, $p<0.001$) and neglect with small effect size ($r=0.18$, $p<0.001$). It is unclear why this is a positive association, unless 'parenting behaviours' refers to poor parenting.
- Stress over parenting and physical abuse with small effect size ($r=0.07$, $p<0.001$) and neglect with small to medium effect size ($r=0.14$, $p<0.001$).

A significant negative association was found between:

- parent-child relationships and physical abuse, with small to medium effect size ($r=-0.27$, $p<0.001$), and neglect with medium to large effect size ($r=-0.48$, $p<0.001$).

Parent characteristics independent of the child

Stith et al. (2009 -) conducted meta-analyses of 19 risk factors which they term as 'parent characteristics independent of the child'. We have separated these into groups of related risk factors, and added in findings from Hindley et al. (2015 ++) where relevant.

Parent characteristics independent of the child – parent age and gender

Stith et al. (2009 -) conducted meta-analyses of the association between parent age and gender, and physical abuse and neglect. Significant negative associations were found between parent age and physical abuse, with small effect size ($r=-0.10$, $p<0.001$), and neglect, with small effect size ($r=-0.12$, $p<0.001$). This suggests that the older the parent, the less likely they are to abuse or neglect their child. A significant association was also found between parent gender and physical abuse, with very small effect size ($r=0.07$, $p<0.001$). However, it is unclear what the correlation refers to here, or which gender is more likely to perpetrate physical abuse. For this reason, we have not developed an evidence statement based on this finding. Stith et al. (2009 -) found no studies exploring the association between parent gender and neglect.

Parent characteristics independent of the child – mental health

Stith et al. (2009 -) conducted meta-analyses looking at the following risk factors relating to mental health: anxiety, psychopathology and depression. Some of the included studies measured these using clinical diagnostic tools (for example, DSM), but others used personality inventories (for example, Cattell's 16 personality factor questionnaire). Not all studies therefore related to diagnosed mental health problems.

Significant positive associations were found for:

- anxiety and physical abuse, with small to medium effect size ($r=0.29$, $p<0.001$); no studies were found exploring the association between this variable and neglect
- psychopathology and physical abuse, with small to medium effect size ($r=0.28$, $p<0.001$) and neglect with small to medium effect size ($r=0.25$, $p<0.001$)
- parent depression and physical abuse, with small to medium effect size ($r=0.27$, $p<0.001$) and neglect, with small to medium effect size ($r=0.21$, $p<0.001$).

Hindley et al. (2015 ++) also found evidence from 5 studies to suggest a significant association between recurrent child maltreatment and parental mental health problems (for example, psychosis, personality disorder) (English 1999; Murphy 1992; Rittner 2002; Swanston 2002; Wood 1997).

Parent characteristics independent of the child – emotional health

Stith et al. (2009 -) conducted meta-analyses examining anger/hyper-reactivity and parental self-esteem. We have categorised these as relating to 'emotional health'. A significant positive association was found between anger/hyper-reactivity and physical abuse, with medium effect size ($r=0.34$, $p<0.001$) and neglect, with medium effect size ($r=0.35$, $p<0.001$). A significant negative relationship was found between parent self-esteem and physical abuse, with small to medium effect size ($r=-0.24$, $p<0.001$) and neglect, with medium effect size ($r=-0.33$, $p<0.001$).

Parent characteristics independent of the child – single parenthood

Stith et al. (2009 -) conducted a meta-analysis of the association between being a single parent and engaging in physical abuse or neglect. There was a significant positive association between being a single parent and physical abuse, with small effect size ($r=0.12$, $p<0.001$) and neglect, with very small effect size ($r=0.08$, $p<0.001$).

Parent characteristics independent of the child – unemployment

Stith et al. (2009 -) conducted a meta-analysis of studies examining the association between parental unemployment and likelihood of perpetrating physical abuse or neglect. They found that there was a significant positive association between unemployment and physical abuse, with small effect size ($r=0.15$, $p<0.001$), and neglect, with small to medium effect size ($r=0.25$, $p<0.001$).

Parent characteristics independent of the child – parent health

Stith et al. (2009 -) conducted a meta-analysis of studies examining the association between parental poor health and likelihood of perpetrating physical abuse. They found that there was not a significant association between parent health problems and perpetrating physical abuse ($r=0.11$, p=ns). No studies were found regarding health problems and neglect.

Parent characteristics independent of the child – substance misuse

Stith et al. (2009 -) conducted meta-analyses examining the association of alcohol and drug misuse with physical abuse. Significant positive associations were found between parental alcohol misuse and physical abuse, with small effect size (r=0.17, p<0.001) and between parental drug misuse and physical abuse, with very small effect size (r=0.08, p<0.05).

In Hindley et al. (2015 ++), 3 studies examined the association between a parental history of substance abuse and maltreatment recurrence (English 1999; Rittner 2002; Swanston 2002). A significant association was found in all 3 studies. One study found a risk ratio for recurrence of maltreatment in parents who abuse drugs of 2.67, 95% CI 1.24-5.74) (Swanston 2002).

Parent characteristics independent of the child – criminal behaviour

Stith et al. (2009 -) conducted a meta-analysis examining the association between parent criminal behaviours and physical abuse. No studies were found regarding criminal behaviour and neglect.

They found a significant positive relationship between parent criminal behaviour and likelihood of perpetrating physical abuse, of small to medium effect size (r=0.21, p<0.001).

Parent characteristics independent of the child – parent childhood experiences

Stith et al. (2009 -) conducted meta-analyses examining rates of abuse among parents who had experienced abuse themselves, and the impact of their relationship with their own parents. Significant positive associations were found between:

- parents who had experienced childhood abuse and went on to perpetrate physical abuse, with small to medium effect size (r=0.21, p<0.001), and neglect with small effect size (r=0.15, p<0.001)
- parents who had a poor relationship with their own parents and went on to perpetrate physical abuse, with small to medium effect size (r=0.22, p<0.001) and neglect with small effect size (r=0.19, p<0.001).

Hindley et al. (2015 ++) reviewed 4 studies of the association between the primary caregiver having been abused as a child. A significant positive association was

reported in 3 studies (English 1999; Rittner 2002; Wood 1997). No effect sizes were reported.

Parent characteristics independent of the child – stress and support

Stith et al. (2009 -) conducted meta-analyses of the association between parent stress and social support, and physical abuse and neglect. A significant positive association was found between parent stress and physical abuse, with small effect size ($r=0.19$, $p<0.001$) and neglect, with medium effect size ($r=0.38$, $p<0.001$). A significant negative association was found between social support and physical abuse, with small effect size ($r=-0.18$, $p<0.001$) and neglect, with small effect size ($r=-0.16$, $p<0.001$). This means that, the greater social support available to individuals, the less likely they are to physically abuse or neglect their children.

Hindley et al. (2015 ++) also cite 1 study in which a significant association was found between higher risk of recurrent maltreatment and parental stress (>1 child in home) ($r=0.26$, $p<0.001$) (Johnson and L'Esperance 1984).

Parent characteristics independent of the child – parenting skills

Stith et al. (2009 -) conducted meta-analyses of the association between parent coping skills and approval of corporal punishment, and likelihood of perpetrating physical abuse or neglect.

A significant negative association was found between parent coping and problem solving skills and physical abuse, of small effect size ($r=-0.14$, $p<0.05$). The authors found no studies examining this relationship for neglect.

No significant association was found between approval of corporal punishment and physical abuse ($r=0.05$, p=ns). The authors found no studies examining this relationship for neglect.

Parent characteristics independent of the child – engagement with services

Hindley et al. (2015 ++) cite 1 study which showed a significant association between attendance at CPS services and reduced risk of recurrence of maltreatment (RR=0.688, p=0.05) (DePanfilis and Zuravin 2002).

Family factors

Stith et al. (2009 -) conducted meta-analysis of 6 potential factors relating to the family. Significant positive associations were found between:

- family conflict and physical abuse, with medium effect size (r=0.39, p<0.001); no studies were found for neglect
- spousal violence and physical abuse, with medium effect size (r=-0.32, p<0.001); no studies were found for neglect
- family size and physical abuse, with small effect size (r=0.15, p<0.001), and neglect, with small to medium effect size (r=0.26, p<0.001).

Significant negative associations were found between:

- family cohesion and physical abuse, with medium effect size (r=-0.32, p<0.001); no studies were found for neglect
- marital satisfaction and physical abuse, with small effect size (r=-0.16, p<0.001); no studies were found for neglect
- socioeconomic status and physical abuse, with small effect size (r=-0.14, p<0.001), and neglect with small effect size (r=-0.18, p<0.001).

Hindley et al. (2015 ++) also cite 1 study which found a significant association between recurrence of maltreatment and having no income (no statistical data reported) (Rittner 2002). It is unclear what is meant by 'no income' in this case – an evidence statement has not been drafted.

Forms of abuse

Hindley et al. (2015 ++) reviewed 7 observational comparative studies examining the association between the impact of type and severity of abuse on recurrence (Depanfilis and Zuravin 1999a, 1999b, 2002; Fluke et al. 1999; Fryer and Miyoshi 1994; Herrenkohl 1979; Murphy et al. 1992, cited in Hindley et al. 2015 ++). The review found that neglect (as opposed to other forms of maltreatment) is the type of abuse most consistently associated with recurrent maltreatment. (DePanfilis 1999b; Fluke 1999; Fryer 1994; Wood 1997 cited in Hindley et al. 2015 ++) – no effect sizes reported.

There was also evidence from 5 observational comparative studies of a significant association between the number of previous episodes of maltreatment and future recurrent maltreatment, with the risk of recurrent maltreatment increasing after each maltreatment event (DePanfilis 1999b; Fluke 1999; Fryer 1994; Herrenkohl et al. 1979; Wood 1997 cited in Hindley et al. 2015 ++) – no effect sizes reported.

There was further evidence from 1 study that the time between episodes of maltreatment significantly shortens as number of maltreatment episodes increases (DePanfilis 2001).

Relative influence of different factors

The Stith et al. (2009 -) review was based on Bronfenbrenner's (1979) ecological theory. The review authors conceptualised a multiple embedded system comprising the following 3 categories of risk factor:

- the parent's relationship to their child
- the parent's characteristics independent of the child
- family characteristics.

The review authors hypothesised that the strongest predictors of abuse and neglect would be within the category of parent-child interaction, as this is the most 'proximal' to the experience of child maltreatment.

This was supported to some extent for data on neglect. This review found that the strongest association with neglect was the quality of parent-child relationships, with a significant negative association with large effect size ($r=-0.48$, $p<0.001$), and the second strongest association was with parents 'perceiving the child as a problem', which showed a significant positive association, also of large effect size ($r=0.41$, $p<0.001$). Among parent characteristics, personal stress showed a significant positive association with neglect of large effect size ($r=0.38$, $p<0.001$). Anger/hyper-reactivity also showed a significant positive effect, with medium to large effect size ($r=0.35$, $p<0.001$).

In contrast, the data for physical abuse did not support the authors' hypothesis that the strongest association would be with factors relating to parent-child interactions. In fact, for physical abuse, family conflict proved to have the strongest association,

with medium effect size (r=0.39, p<0.001). Family cohesion also was found to have a significant negative association with physical abuse, with medium effect size (r=-0.32, p<0.001).

Similar to neglect, anger and hyper-reactivity of the parent and parent perceptions of the child as a problem also showed significant positive associations with physical abuse, with medium effect size (r=0.34, p<0.001 and r=0.30, p<0.001 respectively).

Given the poor quality of this review, and inconclusive evidence in relation to their hypothesis, an evidence statement has not been written in relation to this.

Economics

No economic analysis or modelling was undertaken for this review question.

Evidence statements

ES75	**ES75. Association between maltreatment and internalising behaviour** There is evidence from 1 moderate quality US systematic review (Evans et al. 2008 +) that children who have been exposed to domestic violence are significantly more likely to show internalising behaviours with small to medium effect size (weighted mean effect size =0.48; 95% CI 0.39 to 0.57). There is evidence from a poor quality US systematic review, citing 2 US prospective cohort studies, that psychological neglect at age 3 is associated with internalising behaviour (p<0.01, no effect sizes reported) (Dubowitz et al. 2002, cited in Naughton et al. 2013 -) and environmental neglect at age 5 is associated with internalising behaviour (Dubowitz et al. 2004, cited in Naughton et al. 2013 -).
ES76	**ES76. Association between maltreatment and externalising behaviour** There is evidence from 1 moderate quality US systematic review (Evans et al. 2008 +) that children who have been exposed to domestic violence are significantly more likely to show externalising behaviours, with small to medium effect size (weighted mean effect size =0.47, 95% CI 0.38 to 0.56).This relationship was stronger in boys than in girls, with a small to medium effect size for boys (mean effect size =0.46, 95% CI not reported) and a small effect size for girls (mean effect size =0.23, 95% CI not reported). There is evidence from a poor quality US systematic review (Naughton et al. 2013 -) citing 4 studies, that there is a relationship between neglect and externalising and aggressive behaviour (Dubowitz 2002, p<0.01; Dubowitz 2004, p<0.001; English 2005, p<0.001; Erickson 1989, p<0.01; cited in Naughton et al. 2013 -). Odds ratios/effect sizes are not reported for these studies.
ES77	**ES77. Association between exposure to domestic violence and trauma symptoms** There is evidence from 1 moderate quality US systematic review (Evans et al. 2008 +) that children who have been exposed to domestic violence are

	significantly more likely to show trauma symptoms, with large effect size (mean effect size =1.54, 95% CI 0.38 to 2.71).
ES78	**ES78. Association between maltreatment and emotion skills** There is evidence from 1 moderate quality UK systematic review (Luke and Banerjee 2013 +) that there is a significant negative relationship between experience of physical abuse or neglect and emotion skills, with medium effect size (d=-0.696; 95% CI -0.985 to -0.406). This effect is more pronounced in early childhood (d=-0.933; 95% CI-1.160 to -0.706) compared to middle childhood or adolescence, and more pronounced for emotional understanding (d=-1.351; 95% CI-2.311 to -0.392) compared to emotion knowledge and recognition. There is also evidence from 1 poor quality US systematic review (Naughton et al. 2013 -), citing 1 case control study (Macfie et al. 1999, cited in Naughton et al. 2013 -)and 1 prospective cohort study (Sullivan et al. 2008 -) that neglect is associated with poor emotion skills (no effect sizes reported).
ES79	**ES79. Association between emotional abuse/neglect and attachment** There is evidence from 1 poor quality US systematic review (Naughton et al. 2013 -; 4 studies included) indicating that there is a significant association between neglect and higher rates of insecure-avoidant attachment at age 0 to 20 months (Crittenden et al. 1985, no statistical data; Lamb et al. 1985, $p<0.005$, both cited in Naughton et al. 2013 -) and 5 to 6 years (Venet et al. 2007, cited in Naughton et al. 2013 -) and higher rates of insecure-disorganised attachment at 0 to 20 months (Cicchetti et al. 2006, cited in Naughton et al. 2013 -, $p<0.001$). It should be noted that the quality of reporting of statistical data in this systematic review is poor, meaning it is difficult to have confidence in these findings.
ES80	**ES80. Association between emotional abuse/neglect and cognitive skills and language development** There is evidence from 1 poor quality US systematic review (Naughton et al. 2013 -; 5 studies included) indicating that there is a significant association between neglect and poor cognitive skills at 0 to 20 months (Mackner et al. 1999, cited in Naughton et al. 2013-, $p<0.01$) and 20 to 30 months (Cheatham et al. 2010, cited in Naughton et al. 2013 -, $p<0.001$) and delays in language development at 3 to 4 years (Allen and Oliver 1982, $p<0.001$; Culp et al. 1991, no statistical data reported, both cited in Naughton et al. 2013 -) and 5 to 6 years (Eigsti et al. 2004, cited in Naughton et al. 2013 -, $p<0.04$). It should be noted that the quality of reporting of statistical data in this systematic review is poor, meaning it is difficult to have confidence in these findings.
ES81	**ES81. Association between emotional abuse/neglect and peer relationships** There is evidence from 1 poor quality US systematic review (Naughton et al. 2013 -; 4 studies included) indicating that there is a significant association between neglect and poor peer relationships at 20 to 30 months (DiLalla and Crittenden 1990, cited in Naughton et al. 2013 -, $p<0.001$), 3 to 4 years (Koenig et al. 2000, cited in Naughton et al. 2013 -, no statistical data reported), 4 to 5 years (Hoffman-Plotkin and Twentyman 1984, cited in Naughton et al. 2013 -, $p<0.05$) and 5 to 6 years (Macfie et al. 2001, cited in Naughton et al. 2013 -, no statistical data reported). It should be noted that the quality of reporting of statistical data in this systematic review is poor, meaning it is difficult to have confidence in these findings.

ES82	**ES82. Association between physical abuse and neglect and 'positivity' in interactions with caregivers** There is evidence from 1 moderate quality US systematic review (Wilson et al. 2010 +) that there is a significant negative association between experiencing physical abuse or neglect and rates of positive child behaviour in interactions with caregivers, including affection verbal and physical communication, compliance, cooperation, enthusiasm, positive affect and prosocial behaviour by the child, with small to medium effect size (d=0.42, 95% CI 0.30 to 0.54). This association is more pronounced in children under 4.5 years of age (d=0.57, 95% CI not reported), compared to children aged over 4.5 years (d=0.25, 95% CI not reported), with the relationship between age and effect size approaching statistical significance (r=-0.36, p=0.08).
ES83	**ES83. Association between physical abuse and neglect and 'aversiveness' in interactions with caregivers** There is evidence from 1 moderate quality US systematic review (Wilson et al. 2010 +) that there is a significant association between experiencing physical abuse or neglect and rates of aversive child behaviour in interactions with caregivers, including noncompliance, verbal and physical aggression, hostility and negative mood, with small to medium effect size (d=0.29, 95% CI 0.12 to 0.46).
ES84	**ES84. Association between physical abuse and neglect and 'involvement' in interactions with caregivers** There is evidence from 1 moderate quality US systematic review (Wilson et al. 2010 +) that there is a significant negative association between experiencing physical abuse or neglect and rates of 'involvement' behaviours in interactions with caregivers, including social interaction, requesting information, pointing/social referencing, responding to the caregivers' engagement, with medium effect size (d=0.51, 95% CI 0.25 to 0.77). This effect is more pronounced for neglected children (d=0.75, 95% CI not reported) than for physically abused children (d=0.39, 95% CI not reported), suggesting that rates of involvement behaviours are more useful for identifying neglected children than physically abused children. However, the study authors encourage caution in this conclusion due to the heterogeneity of effect sizes between the studies, and relatively small number of effect sizes for the neglect group (k=6).
ES85	**ES85. Association between neglect and passivity in interactions with caregivers** There is evidence from 1 poor quality US systematic review (Naughton et al. 2013 -; 1 study included) indicating that neglected infants show greater passivity in interactions with their mothers, although the comparison group is unclear (Crittenden 1985, cited in Naughton et al. 2013 -), and a second study which found that neglected infants were more passive initially, but negative behaviours increased with age (12 months onwards up to 2 and a quarter) (Crittenden 1985, cited in Naughton et al. 2013 -, no statistical data reported). It should be noted that the quality of reporting of statistical data in this systematic review is poor, meaning it is difficult to have confidence in these findings.
ES86	**ES86. Association between abuse and neglect and being bullied or a 'bully/victim'** There is evidence from 1 moderate quality meta-analysis of the association between parenting behaviours and bullying (Lereya et al. 2013 +) of a

	statistically significant association between children experiencing abuse or neglect and being bullied, with small effect size (Hedge's g=0.307, 95% CI 0.175 to 0.440) and being a bully/victim, with medium to large effect size (Hedge's g=0.680, 95% CI 0.440 to 0.919).
ES87	**ES87. Association between physical or sexual abuse and young people's drug misuse** There is evidence from 1 poor quality Canadian systematic review (Tonmyr et al. 2010 -) that young people who have experienced physical or sexual abuse are more likely than non-maltreated young people to abuse drugs. This relationship was found in 9 out of 10 included studies of physical abuse and drug use with reported odds ratios for statistically significant studies ranging from 1.8 (95% CI 1.7 to 4.9) and 20.4 (95% CI not reported) and 13 out of 15 included studies of sexual abuse and drug use with reported odds ratios for statistically significant studies ranging from 2.0 (95% CI 1.1 to 3.7) and 8.6 (95% CI not reported). One included study found no statistically significant association between emotional abuse and drug use (Moran et al. 2004, cited in Tonmyr et al. 2010 -).
ES88	**ES88. Association between maltreatment and young people's alcohol use/misuse** There is evidence from 1 poor quality Canadian systematic review (Tonmyr et al. 2010 -) that young people who have experienced maltreatment are more likely than non-maltreated young people to use alcohol. This relationship was found in 11 out of 14 studies of physical abuse and alcohol use with reported odds ratios for statistically significant studies ranging from 1.3 (95% CI 1.0 to 1.8) to 8.9 (95% CI 2.5 to 32.1). A positive association between sexual abuse and alcohol use was also found in 22 out of 24 included studies, with reported odds ratios for statistically significant studies ranging from 1.8 (95% CI 1.1 to 3.0) to 5.2 (95% CI 2.7 to 9.8). One included study found that young people who have been emotionally abused are more likely to use alcohol (Moran et al. 2004, cited in Tonmyr et al. 2010 -, OR=1.5, reported by review authors as significant but 95% CI is not reported). Two studies found that young people who have witnessed domestic violence are more likely to report alcohol use/abuse (Hamburger et al. 2008; Simantov et al. 2000, cited in Tonmyr et al. 2010 -). with odds ratios for significant associations ranging between 1.4 (95% CI 1.1 to 2.0) and 1.9 (95% CI 1.6 to 2.2).
ES89	**ES89. Association between maltreatment and young people's cigarette use** There is evidence from 1 poor quality Canadian systematic review (Tonmyr et al. 2010 -) that young people who have experienced maltreatment are more likely than non-maltreated young people to use cigarettes. This relationship was found in 8 studies of the association between physical abuse and cigarette use with reported odds ratios ranging from 1.8 (95% CI not reported) and 6.1 (95% CI 2.7 to 13.7), 10 out of 11 studies of the association between sexual abuse and cigarette use with reported odds ratios ranging from 2.0 (95% CI 1.6 to 2.5) and 4.2 (95% CI not reported). One included study (Moran et al. 2004, cited in Tonmyr et al. 2010 -) found a significant association between emotional abuse and cigarette use (OR=1.4, 95% CI is not reported). One included study (Simantov et al. 2000, cited in Tonmyr et al. 2010 -) found a significant association between witnessing domestic violence and cigarette use in females (RR=2.2 , 95% CI 1.6 to 3.2) but not males (RR=1.4, 95% CI 0.9 to 2.2).

ES90	**ES90. Association between maltreatment and suicide-related behaviours** There is evidence from 4 moderate quality systematic reviews (Evans et al. 2005 +; Miller et al. 2013 +; Mironova et al. 2011 +; Rhodes et al. 2011 +) that experience of physical abuse is significantly associated with increased likelihood of suicide-related behaviours, including suicidal ideation, suicidal thoughts and plans and suicide attempts. Unadjusted odds ratios for physical abuse range from 1.9 (95% CI 1.5 to 2.4, Evans et al. 2005) to 3.7 (95% CI not reported, Mironova et al. 2013 +). The size of the effect was more varied for sexual abuse, with 1 systematic review reporting unadjusted odds ratios ranging from 1.5 (95% confidence interval 1.2 to 1.9) to 47.1 (95% confidence interval 23.2 to 95.3) (Evans et al. 2005 +). One systematic review found that the association between sexual abuse and suicide-related behaviours was stronger for boys, for whom odds ratios ranged between 1.9 (95% CI 1.1 to 3.2) and 27.8 (95% CI 9.8 to 78.9) than for girls, for whom odds ratios ranged between 1.1 (95% CI 0.8 to 1.7) and 6.8 (95% CI 4.5 to 10.2 95% CI). No odds ratios were reported for emotional abuse or neglect. There was some evidence that the association was stronger for more severe forms of abuse: 2 studies found the more severe the physical abuse, the greater likelihood of suicide-related behaviours (Fergusson and Lynskey 1997, cited in Mironova et al. 2011 +; Jones et al. 1992, cited in Evans et al. 2005 +) and 1 study that more serious sexual abuse was associated with an increased likelihood of suicide-related behaviours (Bensley et al. 1999, cited in Evans et al. 2005 +).
ES93	**ES93. Association between maltreatment and language ability** This evidence statement is based on 1 moderate quality US prospective cohort study (Noll et al. 2010 +) and 8 observational comparative studies, comprising 5 that were moderate quality US studies (De Bellis et al. 2009 +; Eigsti and Cicchetti 2004 +; Pears and Fisher 2005 +; Prasad et al. 2005 +; Spratt et al. 2012), 1 that was a moderate quality UK study (Kocovska et al. 2012 +), 1 a poor quality US study (Gilbert et al. 2013 -) and 1 a poor quality Canadian study (Nolin and Ethier 2007 -). There is evidence that experience of maltreatment is significantly negatively associated with language ability. Eight of the 9 studies showed a significant negative association between child experience of maltreatment (described as either 'maltreatment', physical abuse or neglect) and at least 1 measure of language ability (De Bellis et al. 2009 +; Eigsti and Cicchetti 2004 +; Gilbert et al. 2013 -; Kocovska et al. 2012 +; Pears and Fisher 2005 +; Prasad et al. 2005 +; Spratt et al. 2012). One study calculated an adjusted odds ratio of missing developmental milestones for language of 1.4 (95% CI 1.1 to 1.9) (Gilbert et al. et al. 2013 -), 5 showed medium or large effect sizes (partial eta squared=0.16, De Bellis et al. 2009; ES=-0.78, Eigsti and Cicchetti 2004; ES=1.14, Kocovska et al. 2012; ES=-0.78, Pears and Fisher 2005; ES=-1.0, Prasad et al. 2005 ES=-1.0). Effect sizes were not available for 2 studies showing significant data. One study found no association on any measure (ES=0.020, Nolin and Ethier 2007) but this measured receptive language only. One study found differences in language development following sexual abuse, but only between ages 15 to 18 rather than in childhood (Noll et al. 2010 +).
ES94	**ES94. Association between sexual and physical abuse and features of children's drawings**

	There is evidence from 1 poor quality systematic review of 23 controlled comparative studies (Allen et al. 2012 -) that there is no reliable association between physical or sexual abuse and features of children's drawings (no effect sizes reported).
ES95	**ES95. Association between child disability and abuse/neglect** There is evidence from 1 moderate quality meta-analysis (Jones et al. 2012 +) and 1 good-quality systematic review (Govindshenoy et al. 2006 ++) that disabled children are more likely to experience all forms of abuse and neglect. The meta-analysis resulted in pooled odds ratios for children with any disability ranging from 2.88 (95% CI 2.24-3.69) for likelihood of sexual violence, to 4.56 (95% CI 3.23-6.43) for likelihood of neglect. A conflicting result was found by a poor quality meta-analysis (Stith et al. 2009 -), but this may be due to the small sample sizes of included studies. There is some evidence to suggest that risk may be higher for children with psychological disorders or learning difficulties. One meta-analysis (Jones et al. 2012 +) found higher pooled odds ratios for this group than for the 'any disability' group for likelihood of 'any maltreatment' (OR=2.12-8.62) and for likelihood of sexual violence (OR=4.62, 95% CI 2.08-10.23), although the statistical significance of these differences was not tested. There is some evidence to suggest (Spencer et al. 2005, cited in Govindshenoy) that there is no significantly greater likelihood of abuse for children with sensory disorders and autism than for non-disabled children.
ES96	**ES96. Association between age of child and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis (Stith et al. 2009 -) that there is not a significant association between child age and experiencing physical abuse (r=-0.02, p>0.05) or neglect (r=-0.01, p>0.05).
ES97	**ES97. Association between age of child and recurrence of abuse** There is equivocal evidence from 1 good quality systematic review regarding the association between age and recurrence of maltreatment. Four out 7 studies cited in the systematic review found that younger children were at greater risk of recurrence of maltreatment (English et al. 1999; Fluke et al. 1999; Fryer and Miyoshi 1994; Herrenkohl et al. 1979, cited in Hindley et al. 2015 ++), but 3 found no association (Murphy et al. 1992; Rivara 1985; Swanston et al. 2002).
ES98	**ES98. Association between gender of child and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis (Stith et al. 2009 -) that there is not a significant association between child gender and experiencing physical abuse (r=-0.04, p>0.05) or neglect (r=0.01, p>0.05).
ES99	**ES99. Association between gender of child and recurrence of abuse** There is evidence from 1 good quality systematic review (Hindley et al. 2015++) that there is no association between child gender and recurrence of maltreatment.
ES100	**ES100. Association between internalising and externalising behaviour and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis (Stith et al. 2009 -) that there is a significant association between externalising behaviour and physical abuse of small to medium effect size (r=0.23, p<0.001), and between externalising behaviour and neglect of small effect size (r=0.11, p<0.001). The study also found a significant association between internalising behaviour and physical abuse of small effect size (r=0.15,

	p<0.001) and between internalising behaviour and neglect of small effect size (r=0.11, p<0.001). However, it should be noted that association does not describe the direction of causation.
ES101	**ES101. Association between child social competency and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis (Stith et al. 2009 -) of a significant negative association between child social competence and physical abuse with small to medium effect size (r=-0.26, p<0.001) but a significant positive association between child social competence and neglect with small effect size (r=0.11, p<0.001). The positive association is unexpected as it implies that as child social competence increases, the likelihood of neglect also increases.
ES102	**ES102. Association between prenatal/neonatal problems and physical abuse** There is evidence from 1 poor quality meta-analysis (Stith et al. 2009 -) that there is not a significant association between prenatal/neonatal problems and physical abuse (r=0.04, p>0.05).
ES103	**ES103. Association between risk factors relating to parent–child interaction and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis (Stith et al. 2009 -) that there is a significant association between a range of parent–child interaction risk factors and physical abuse and neglect. There is evidence of significant positive associations between the parent perceiving the child as a problem and physical abuse with medium effect size (r=0.30, p<0.001), and neglect with medium to large effect size (r=0.41, p<0.001); parenting behaviours and physical abuse, with small effect size (r=0.17, p<0.001) and neglect with small effect size (r=0.18, p<0.001); and stress over parenting and physical abuse with very small effect size (r=0.07, p<0.001) and neglect with small to medium effect size (r=0.14, p<0.001). There is evidence of a significant negative association between parent–child relationships and physical abuse, with small to medium effect size (r=-0.27, p<0.001), and neglect with medium to large effect size (r=-0.48, p<0.001).
ES104	**ES104. Association between risk factors relating to parent–child interaction and physical abuse** There is evidence from 1 poor quality meta-analysis (Stith et al. 2009 -) that there is a significant association between a range of parent–child interaction risk factors and physical abuse. Significant positive associations were found for unplanned pregnancy with small to medium effect size (r=0.28, p<0.001) and parent use of corporal punishment with small to medium effect size (r=0.26, p<0.001). It is unclear why this is a positive association, unless 'parenting behaviours' refers to poor parenting.
ES105	**ES105. Association between parent age and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) that there is a significant negative association between parent age and physical abuse, with small effect size (r=-0.10, p<0.001), and neglect, with small effect size (r=-0.12, p<0.001).
ES106	**ES106. Association between parental mental health and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) that there is a significant

	association between parental mental health and physical abuse and neglect. Significant positive associations were found for psychopathology and physical abuse, with small to medium effect size (r=0.28, p<0.001) and neglect with small to medium effect size (r=0.25, p<0.001); parent depression and physical abuse, with small to medium effect size (r=0.27, p<0.001) and neglect, with small to medium effect size (r=0.21, p<0.001). A significant positive association was found between anxiety and physical abuse, with small to medium effect size (r=0.29, p<0.001). No studies were found exploring the association between anxiety and neglect.
ES107	**ES107. Association between parental mental health and recurrence of maltreatment** There is evidence from 1 good quality systematic review (Hindley et al. 2015 ++) citing 5 observational comparative studies (English 1999; Murphy 1992; Rittner 2002; Swanston 2002; Wood 1997) that there is a significant association between recurrent child maltreatment and parental mental health problems.
ES108	**ES108. Association between parental emotional health and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) that there is a significant association between parental emotional health and physical abuse and neglect. A significant positive association was found between anger/hyper-reactivity and physical abuse, with medium effect size (r=0.34, p<0.001) and neglect, with medium effect size (r=0.35, p<0.001). A significant negative relationship was found between parent self-esteem and physical abuse, with small to medium effect size (r=-0.24, p<0.001) and neglect, with medium effect size (r=-0.33, p<0.001).
ES109	**ES109. Association between single parenthood and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) that there is a significant positive association between being a single parent and physical abuse, with small effect size (r=0.12, p<0.001) and neglect, with very small effect size (r=0.08, p<0.001).
ES110	**ES110. Association between parental unemployment and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) of a significant positive association between unemployment and physical abuse, with small effect size (r=0.15, p<0.001), and neglect, with small to medium effect size (r=0.25, p<0.001).
ES111	**ES111. Association between parental ill health and physical abuse** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) that there is not a significant association between parent health problems and perpetrating physical abuse (r=0.11, p=ns).
ES112	**ES112. Association between parental substance misuse and physical abuse of the child** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) of a significant positive association between parental alcohol misuse and physical abuse, with small effect size

	(r=0.17, p<0.001) and between parental drug misuse and physical abuse, with very small effect size (r=0.08, p<0.05).
ES113	**ES113. Association between parental substance abuse and recurrence of maltreatment** There is evidence from 1 good quality systematic review (Hindley et al. 2015 ++) citing 3 observational comparative studies of a significant association between a parental history of substance abuse and maltreatment recurrence (English 1999; Rittner 2002; Swanston 2002). One study found a risk ratio for recurrence of maltreatment in parents who abuse drugs of 2.67, 95% (CI 1.24 to 5.74) (Swanston 2002).
ES114	**ES114. Association between parent criminal behaviour and physical abuse of the child** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) of a significant positive association between parent criminal behaviour and likelihood of perpetrating physical abuse, of small to medium effect size (r=0.21, p<0.001).
ES115	**ES115. Association between caregiver childhood experiences and physical abuse and neglect** There is evidence from 1 poor-quality meta-analysis (Stith et al. 2009 -) of a significant positive association between parents who had experienced childhood abuse and went on to perpetrate physical abuse, with small to medium effect size (r=0.21, p<0.001), and neglect with small effect size (r=0.15, p<0.001); and parents who had a poor relationship with their own parents and went on to perpetrate physical abuse, with small to medium effect size (r=0.22, p<0.001) and neglect with small effect size (r=0.19, p<0.001).
ES116	**ES116. Association between caregiver childhood experiences and recurrence of maltreatment** There is evidence from 1 good quality systematic review (Hindley et al. 2015 ++) citing 3 observational comparative studies (English 1999; Rittner 2002; Wood 1997) of a significant positive association between the primary caregiver having been abused as a child, and recurrence of maltreatment. No effect sizes reported.
ES117	**ES117. Association between stress and support and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) that there is a significant positive association between parent stress and physical abuse, with small effect size (r=0.19, p<0.001) and neglect, with medium effect size (r=0.38, p<0.001). A significant negative association was found between social support and physical abuse, with small effect size (r=-0.18, p<0.001) and neglect, with small effect size (r=-0.16, p<0.001).
ES118	**ES118. Association between stress and recurrence** There is evidence from 1 good quality systematic review (Hindley et al. 2015 ++) citing 1 observational comparative study (Johnson and L'Esperance 1984) that there is a significant positive association between parental stress and recurrence of maltreatment (r=0.26, p<0.001).
ES119	**ES119. Association between parenting skills and physical abuse** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) of a significant negative association between parent coping and problem solving skills and physical

	abuse, of small effect size (r=-0.14, p<0.05). No significant association was found between approval of corporal punishment and physical abuse (r=0.05, p=ns).
ES120	**ES120. Association between engagement with services and risk of recurrence of maltreatment** There is evidence from 1 good quality systematic review (Hindley et al. 2015++), citing 1 observational comparative study (DePanfilis and Zuravin 2002) of a significant association between attendance at CPS services and reduced risk of recurrence of maltreatment (RR=0.688, p=0.05).
ES121	**ES121. Association between family factors and physical abuse and neglect** There is evidence from 1 poor quality meta-analysis of observational comparative studies (Stith et al. 2009 -) that a range of factors relating to the family are associated with increased likelihood of physical abuse, including 'spousal violence', with medium effect size (r=-0.32, p<0.001); family size, with small effect size (r=0.15, p<0.001); poorer family cohesion (r=-0.32, p<0.001); and lower marital satisfaction, with small effect size (r=-0.16, p<0.001). Family size was also found to be associated with neglect, with small to medium effect size r=0.26, p<0.001), as was socioeconomic status, with small effect size (r=-0.18, p<0.001). No data were reported on the association between neglect and spousal violence, family cohesion or marital satisfaction.
ES122	**ES122. Association between form of abuse and recurrence** There is evidence from 1 good quality systematic review (Hindley et al. 2015 ++) citing 4 observational comparative studies that neglect (as opposed to other forms of maltreatment) is the type of abuse most consistently associated with recurrent maltreatment. (DePanfilis 1999b; Fluke 1999; Fryer 1994; Wood 1997), no effect sizes reported.
ES123	**ES123. Association between number of episodes of maltreatment and recurrence** There is evidence from 1 good quality systematic review (Hindley et al. 2015 ++) citing 5 observational comparative studies of a significant association between the number of previous episodes of maltreatment and future maltreatment, with the risk of recurrent maltreatment increasing after each maltreatment episode (DePanfilis 1999b; Fluke 1999; Fryer 1994; Herrenkohl et al. 1979; Wood 1997), no effect sizes reported.

Included studies for these review questions

Allen B and Tussey C (2012) Can projective drawings detect if a child experienced sexual or physical abuse? A systematic review of the controlled research. Trauma, Violence, and Abuse: A Review Journal 13: 97-111

De Bellis MD, Hooper SR, Spratt EG et al. (2009) Neuropsychological findings in childhood neglect and their relationships to pediatric PTSD. Journal of the International Neuropsychological Society 15: 868-78

Eigsti I and Cicchetti D (2004) The impact of child maltreatment on expressive syntax at 60 months. Developmental Science 7: 88-102

Evans E, Hawton K, Rodham K (2005) Suicidal phenomena and abuse in adolescents: a review of epidemiological studies. Child Abuse and Neglect 29: 45-58

Evans SE, Davies C, DiLillo D (2008) Exposure to domestic violence: a meta-analysis of child and adolescent outcomes. Aggression and Violent Behavior 13: 131-40

Gilbert AL, Bauer NS, Carroll AE et al. (2013) Child exposure to parental violence and psychological distress associated with delayed milestones. Pediatrics 132: e1577-83

Govindshenoy M and Spencer N (2006) Abuse of the disabled child: a systematic review of population-based studies. Child: Care, Health and Development 33: 552-8

Hindley N, Ramchandani PG, Jones DPH (2006) Risk factors for recurrence of maltreatment: a systematic review. Archives of Disease in Childhood 91: 744-52

Jones L, Bellis MA, Wood S et al. (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. Lancet 380: 899-907

Kočovská E, Puckering C, Follan M et al. (2012) Neurodevelopmental problems in maltreated children referred with indiscriminate friendliness. Research in Developmental Disabilities 33: 1560-5

Lereya ST, Samara M, Wolke D (2013) Parenting behavior and the risk of becoming a victim and a bully/victim: a meta-analysis study. Child Abuse & Neglect 37: 1091-108

Luke N and Banerjee R (2013) Differentiated associations between childhood maltreatment experiences and social understanding: a meta-analysis and systematic review. Developmental Review 33: 1-28

Miller AB, Esposito-Smythers C, Weismoore JT et al. (2013) The relation between child maltreatment and adolescent suicidal behavior: a systematic review and critical

examination of the literature. Clinical Child and Family Psychology Review 16: 146-72

Mironova P, Rhodes AE, Bethell Jennifer M et al. (2011) Childhood physical abuse and suicide-related behavior: a systematic review. Vulnerable Children and Youth Studies 6: 1-7

Naughton AM, Maguire SA, Mann MK et al. (2013) Emotional, behavioral, and developmental features indicative of neglect or emotional abuse in preschool children: a systematic review. JAMA Pediatrics 167: 769-75.

Nolin P and Ethier L (2007) Using neuropsychological profiles to classify neglected children with or without physical abuse. Child Abuse and Neglect 31: 631-43

Noll JG, Shenk CE, Yeh MT et al. (2010) Receptive language and educational attainment for sexually abused females. Pediatrics 126: e615-22

Pears K and Fisher PA (2005) Developmental, cognitive, and neuropsychological functioning in preschool-aged foster children: associations with prior maltreatment and placement history. Journal of Developmental and Behavioral Pediatrics 26: 112-22

Prasad MR, Kramer LA, Ewing-Cobbs L (2005) Cognitive and neuroimaging findings in physically abused preschoolers. Archives of Disease in Childhood 90: 82-5

Rhodes AE, Boyle MH, Tonmyr L et al. (2011) Sex differences in childhood sexual abuse and suicide related behaviors. Suicide & Life-threatening Behavior 41: 235-54.

Spratt EG, Friedenberg S, LaRosa A et al. (2012) The effects of early neglect on cognitive, language, and behavioral functioning in childhood. Psychology 3: 175-82

Stith SM, Liu T, Davies LC (2009) Risk factors in child maltreatment: a meta-analytic review of the literature. Aggression and Violent Behavior 14: 13-29

Tonmyr L et al. (2010) A review of childhood maltreatment and adolescent substance use relationship. Current Psychiatry Reviews 6(3): 223-34.

Wilson SR, Norris AM, Shi X al. (2010) Comparing physically abused, neglected, and nonmaltreated children during interactions with their parents: a meta-analysis of observational studies. Communication Monographs 77: 540-75

3.2 Recognition of abuse and neglect – tools

Introduction to the review question

There is debate in practice regarding whether practitioner judgement in recognising abuse and neglect can be enhanced by the use of standardised tools. The purpose of this review question was to assess what tools support effective recognition of child abuse and neglect, and the taking of proportionate action.

For the purpose of the review, tools were defined as standardised tools to assist recognition of child abuse and neglect. This could include tools developed on the basis of consensus or those which are empirically/statistically based, including screening tools and checklists, or components relevant to recognition within systems of tools.

All the studies we found that met the review protocol criteria for this question were rated as poor quality. This may reflect to some extent the fact that all the tools were being implemented and evaluated in the context of 'real' ongoing practice, rather than as part of a trial. For both studies about the National Institute of Child Health and Human Development (NICHD) Investigative Interview protocol (Hershkowitz et al. 2007 -, 2014 -) there was a lack of information regarding study procedures, which limited our confidence in the results. For the study regarding screening at emergency departments (Louwers et al. 2012 -), again reporting of the design and process was somewhat confused, and it appeared that numerous screening tests had been used in both the pre- and post-intervention phases of the study, and in both 'test' and 'control' hospitals.

Review questions

5. What tools support effective recognition of child abuse and neglect, and the taking of proportionate action?

Summary of the review protocol

The protocol sought to identify studies that would:

- assess what tools (for example, screening tools) are effective in supporting practitioners to recognise abuse and neglect in children and young people.
- assess what tools (for example, screening tools) and ways of working are cost effective.

The protocol for question 5 sought to identify comparative studies which compared the tool with usual process (without use of specific tool); or were a comparison of 1 or more different tools, and which examined either the predictive validity of the tool in terms of its ability to correctly identify families at risk of or experiencing abuse or neglect, its impact on service user outcomes or its acceptability to children and families. The study designs included for these questions were randomised or quasi-randomised controlled trials; impact evaluation (for example, prospective comparative evaluation), economic evaluation or systematic reviews of these studies.

Full protocols can be found in Appendix A.

Population

Children and young people (under 18) who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families.

Practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families. For example, social workers, health professionals, those working in education, voluntary sector providers.

Intervention

Use of standardised tools to assist recognition of child abuse and neglect. This may include tools developed on the basis of consensus (expert opinion about risk/likelihood of harm) or those which are empirically/statistically based. For recognition, this may include screening tools and checklists, or components relevant to recognition within systems of tools (that is, packages comprising a range of tools for use at different stages of the decision-making process).

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children's own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings
- schools and colleges
- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Predictive validity of tool; acceptability to children, young people and their caregivers and families (including as reported by adult survivors of child abuse and neglect); quality of parenting and parent-child relationships, including quality of attachment, children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM)); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials

registries were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and October 2014. Update searching of the bibliographic databases searches took place in April 2016.

Summary from re-run searches

An updated search was carried out in April 2016 to identify any new studies relating to the effectiveness questions (5, 7, 9-13, 15-19) published since the original searches were conducted for this guideline. This search used the same search terms and databases as the main search.

As we originally conducted a single search for all of the original 21 questions, the search identified a large number (10,833) of items which we used as a 'database' within which to search for studies relevant to our questions. This included specific searches for interventions for which evidence had already been reviewed.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope.

Search outputs were screened in several stages, as described at the beginning of section 3. Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific criteria for those questions. For question 5 these were as follows:

- evidence type (study must be a longitudinal, cohort, cross-sectional or case control study or systematic review/meta-analysis of studies of these designs)
- population (children and young people under 18 who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families).

Based on these criteria we identified 78 studies for screening on full text. Full texts were again reviewed for relevance and research design. Following full text screening, 3 studies were included.

Included papers were critically appraised using tools agreed by NICE and data extracted using a coding set developed to reflect the review questions. See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence

1. Investigative interviewing protocols

Description of evidence

We found 2 poor quality Israeli quasi-experimental studies exploring the effectiveness of the National Institute of Child Health and Human Development (NICHD) Investigative Interview protocol in achieving accurate and credible interviews with children suspected to have experienced abuse (Hershkowitz et al. 2007 -, 2014 -).

Hershkowitz et al. (2007 -) examined interviews with children suspected to have been sexually abused. Interviews were conducted either using the NICHD protocol,

or in an unstructured way. The children interviewed using protocol versus non-protocol interviews were reported to have been matched in terms of age and type of allegation, although the characteristics of the children are not given in the study. A sample of 24 interview transcripts were selected in which half were judged to be 'plausible' allegations and half 'implausible', based on corroborating evidence assessed by 3 experts (including physical and medical evidence, witness and suspect statements). The allocation of interviews to the study conditions is shown in Table 6 below.

Table 6. Interview numbers per condition for Hershkowitz et al. (2007 -)

	Interviewed using NICHD protocol	**Not interviewed using protocol**
Allegation judged to be 'plausible' on basis of corroborating evidence	6	6
Allegation judged to be 'implausible' on basis of corroborating evidence	6	6
Total	12	12

The interview transcripts were then assessed by 42 Israeli youth investigators, who were blind to whether the allegation had been judged to be 'plausible'. The investigators assessed whether the child's account in the interview was 'credible' (that is, it was very likely or quite likely that abuse had taken place), or 'incredible' (quite unlikely or very unlikely that abuse had taken place). The youth investigators could also rate using a 'No judgement possible' option. Their credibility judgements were then compared to the ratings of plausibility made on the basis of corroborating evidence.

This study was rated as poor because little information is provided regarding characteristics of the child interviewees – it is therefore unclear if interviews were 'typical' or 'atypical' cases. There was also limited information on statistical tests of relative accuracy of judgements for protocol versus non-protocol interviews. The study authors also note that, in real practice, youth investigators would witness the interviews, rather than simply read the transcripts, and so would also have non-verbal information to contribute to their judgement. There is also no consideration in

the study of whether the protocol compared to non-structured interviews differed in terms of style and content, although this is assumed to be the case.

Hershkowitz et al. (2014 -) investigated whether a particular type of interview protocol supports more children to make allegations of abuse. A total of 426 Israeli children aged 4-13 years, who were suspected victims of intrafamilial physical or sexual abuse, were interviewed. All cases had been corroborated by independent external evidence, such as witness testimony or medical evidence. The NICHD Investigative Interview Standard Protocol (SP) was used to conduct 165 interviews and 261 were conducted using a revised version of this protocol (RP), following a 2-day training course for interviewers. Changes in the revised protocol included changes made to the structure and language in order to build better rapport between the interviewer and child, and clearer instructions regarding a range of practices including reassurance, legitimising the child's contributions, empathy and so on. The interviews were coded as to whether the child had made an allegation or not during the course of the interview.

The study was rated as poor because, although the authors briefly describe their definition of what constitutes an 'allegation', little detail is given regarding how the presence of allegations in the interviews were identified, by whom, and whether there was any double-coding of the interviews. Given that the presence of absence of allegations in the principle outcome measure of the study, we considered this to be a significant flaw.

Narrative summary

Hershkowitz et al. (2007 -) found that there was a significantly higher rate of accurate judgement of credibility for interviews undertaken using the NICHD protocol, compared to unstructured interviews. This was the case for both plausible cases, with large effect size ($p<0.001$, $d=1.92$) and implausible cases, with small to medium effect size ($p<0.001$, $d=0.46$). The 'no judgement possible' option was used significantly more frequently for non-protocol interviews, with large effect size ($p<0.019$, $d=0.94$).

Hershkowitz et al. (2014 -) found that there was a higher allegation rate when using the revised compared to the standard protocol (59.8% compared to 50.3%). They

also used logistic hierarchical linear modelling to determine the association between protocol version and allegation rates, while controlling for the effects of other variables. The study found that there was a statistically significant relationship between protocol version and allegation rates (b=0.450, p=0.036) when taking variables such as age, gender and abuse type in to account.

2. Screening for child abuse in emergency departments

Description of evidence

We found 1 poor-quality Dutch quasi-experimental study, using a pre-post design (Louwers et al. 2012 -), which examined the effectiveness of screening for abuse and neglect in 7 hospital emergency departments. The study states that it is focusing on the 'Escape form' checklist, a checklist containing 6 'warning signs' for child abuse (list of warning signs not given in the study). However, in fact participating sites were using a range of screening forms, the details of which are not reported. Suspected cases of abuse identified using the checklist(s) were validated by a panel of experts. The study compared the rate of detection of abuse amongst children who were screened, and those who were not screened.

The study was rated as poor because the design of the study is unclear: for example, a number of hospitals were designated as 'control' hospitals, but appear to have been included in the analysis of screening rates, suggesting that screening tools were also implemented in these settings. The fact that a range of different screening tools were implemented in the different hospitals also makes the results difficult to interpret. Finally, the study would have been more robust if suspected cases of abuse identified using the tool had been validated using a more objective measure, such as the outcome of a child protective services investigation, rather than by an expert panel.

Narrative summary

The study found that, of the 104,028 children who attended emergency departments during the study, 37,404 were screened for child abuse and 66,624 were not. The overall detection rate for abuse during the 23-month period was 0.2%. The detection rate was significantly higher for screened children compared to those not screened (0.5% vs 0.1%, p<0.001). The pooled odds ratio for detection amongst screened

compared to non-screened children across the 7 hospitals was OR=4.88 (95% CI 3.58 to 6.68), meaning that abuse was nearly 5 times more likely to be detected in children who were screened that those who were not.

However, it should be noted that, in this study, 'detected' cases of abuse were not determined by, for example, the outcome of the children's services investigation. Instead, cases detected by the checklist were validated by a panel of experts reviewing case file data to determine whether the case was likely to be abuse. The authors acknowledge that the number of 'detected' cases is therefore likely to be an over-estimate. It should also be noted that:

- the study includes a range of screening tools, not just the 'Escape form' which appeared to be the main subject of the study
- some sites received training as well as using the checklist, but some did not; it is therefore unclear how much of the effect is due to the training and how much to the checklists.

Economics

No economic analysis or modelling was undertaken for this review question.

Evidence statements

For details of how the evidence is graded and on writing evidence statements, see Developing NICE guidelines: the manual.

ES136	**ES136. Effectiveness of an investigative interviewing protocol compared to unstructured interviews** There is evidence from 1 poor quality quasi-experimental Israeli study Hershkowitz et al. (2007 -) that use of a structured interviewing protocol (the National Institute of Child Health and Human Development Investigative Interview protocol) with children who are suspected to have experienced sexual abuse, compared to conducting unstructured interviews, leads to significantly more accurate identification of 'plausible' accounts of abuse, with large effect size ($p<0.001$, $d=1.92$), and significantly more accurate identification of 'implausible' accounts with small to medium effect size ($p<0.001$, $d=0.46$). This study was rated as poor because little information is provided regarding characteristics of the child interviewees, making it unclear if interviews were 'typical' or 'atypical' cases. There is also no consideration in the study of whether the protocol

	compared to non-structured interviews differed in terms of style and content, although this is assumed to be the case.
ES137	**ES137. Effectiveness of a revised compared to standard investigative interviewing protocol** There is evidence from 1 poor-quality quasi-experimental Israeli study (Hershkowitz et al. 2014 -) that use of a revised version of the National Institute of Child Health and Human Development Investigative Interview protocol, with a greater emphasis on rapport building and providing non-suggestive support to make allegations, is statistically significantly associated with higher frequency of allegations made in investigative interviews with children who have experienced physical or sexual abuse (b=0.450, p=0.036, effect size not reported or calculable). The study was rated as poor due to lack of information regarding how 'allegations' were defined and coded.
ES138	**ES138. Effectiveness of screening for abuse and neglect in emergency departments** The evidence from 1 poor quality prospective Dutch evaluation (Louwers et al. 2012 -), assessing the effectiveness of screening at emergency departments in improving rate of detection of abuse and neglect is of insufficient quality to draw any reliable conclusions.

Included studies for these review questions

Hershkowitz I, Fisher S, Lamb ME et al. (2007) Improving credibility assessment in child sexual abuse allegations: the role of the NICHD investigative interview protocol. Child Abuse and Neglect 31: 99-110

Hershkowitz I, Lamb ME, Katz C (2014) Allegation rates in forensic child abuse investigations: comparing the revised and standard NICHD protocols. Psychology, Public Policy, and Law 20: 336-44

Louwers EC, Korfage I, Affourtit MJ et al. (2012) Effects of systematic screening and detection of child abuse in emergency departments. Pediatrics 130: 457-64

3.3 Recognition of abuse and neglect – aspects of professional practice

Introduction to the review question

The purpose of this review question was to assess what aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action. 'Aspects of professional practice' were defined as including

issues such as professionals' knowledge, attitudes and beliefs about abuse and neglect; professionals' concepts of their role in relation to abuse and neglect, and common errors of professional reasoning. This question was intended to complement question 5 (relating to standardised tools to support recognition) by examining general ways of working and approaches which may help and hinder recognition. The question also used relevant data from questions on views and experiences of children, young people, adult survivors of abuse, parents, carers and practitioners (questions 1 and 2).

Of the 19 studies included for this question, 1 was a poor quality systematic review (Daniel et al. 2009 -) and the remainder were qualitative studies with either children and young people, caregivers or professionals. Of the qualitative studies, 6 were rated as good quality (++), 6 were rated as moderate quality (+) and 6 were rated as poor quality (-). Common methodological flaws in the poor quality, and some of the moderate quality studies, included: insufficient consideration and reporting of ethics procedures, including obtaining informed consent; limited information regarding methodology, including sampling, data collection and analysis; and little consideration of context or diversity of opinion between participants in some studies. Some of these limitations may reflect the fact that a number of these papers are 'grey' literature published by charities and campaigning organisations, rather than peer-reviewed studies.

Review questions

6. What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action?

Question 6 also included material relevant to the following questions.

1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing

early help for, or intervention following, abuse and neglect of children and young people?

Summary of the review protocol

For question 6, the protocol sought to pinpoint studies that would identify what aspects of professional practice support and hinder recognition of child abuse and neglect, and taking proportionate action. The views and experiences of children, young people, parents and carers (question 1) and practitioners (question 2) were analysed as part of this question where relevant.

The study designs included for question 6 were process evaluation, ethnographic and observational studies of practice, analyses of serious case review data and systematic reviews of these. Study designs included for questions 1 and 2 were qualitative studies, qualitative components of effectiveness and mixed methods studies; survey studies and systematic reviews of these studies.

Full protocols can be found in Appendix A.

Population

For question 6:

Children and young people (under 18) who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families.

Practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families. For example, social workers, health professionals, those working in education, voluntary sector providers.

For question 1:

Children and young people (under 18) who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families.

Adults over the age of 18 who experienced abuse or neglect as children reporting their childhood experiences.

For question 2:

Practitioners working with children and young people at risk of, experiencing, or who have experienced abuse and neglect, and/or their caregivers and families. For example, social workers, health professionals, those working in education, voluntary sector providers.

Intervention

Not applicable.

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children's own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings
- schools and colleges
- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Acceptability to children, young people and their caregivers and families (including as reported by adult survivors of child abuse and neglect); incidence of abuse and neglect; quality of parenting and parent-child relationships, including quality of attachment, children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM)); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials registries were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and October 2014. Update searching of the bibliographic databases searches took place in April 2016.

Summary from re-run searches

An updated search was carried out in April 2016 to identify any new studies relating to the effectiveness questions (5, 7, 9-13, 15-19) published since the original

searches were conducted for this guideline. This search used the same search terms and databases as the main search.

As we originally conducted a single search for all of the original 21 questions, the search identified a large number (10,833) of items which we used as a 'database' within which to search for studies relevant to our questions. This included specific searches for interventions for which evidence had already been reviewed.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope.

Search outputs were screened in several stages, as described at the beginning of section 3. Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific criteria for those questions, based on the PICO criteria for that question. For question 6 these were as follows:

- country (study is not from Europe, Israel, Australia, Canada, USA, New Zealand)
- evidence (not an empirical study including process evaluation, ethnographic and observational studies of practice, analysis of serious case review data)
- population (study population is not children and young people who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families or practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families – for example social workers, health professionals, those working in education, voluntary sector providers)
- topic (study does not relate to identifying what aspects of professional practice support and hinder recognition of child abuse and neglect, and taking proportionate action).

For questions 1 and 2 these were as follows:

- country (study is not from the UK)
- evidence (not an empirical study including qualitative studies, qualitative components of effectiveness and mixed methods studies, survey studies or systematic reviews of these study types)
- population (population is not children and young people who are at risk of, are experiencing, or have experienced abuse or neglect; their caregivers and families; adult survivors of abuse or neglect; practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families)
- topic (study does not relate to the process of recognising abuse and/or neglect, the process of assessment, services providing early help, services providing intervention following abuse or neglect).

The early stages of screening identified an extremely high number of studies which could potentially be considered for this question (n=1223). A decision was therefore taken to:

- restrict the evidence for Q6 to UK studies only – this is in line with the inclusion/exclusion criteria for Qs 1 and 2 (this restricted numbers to n=274)
- of those, to focus further screening on studies which had a clear mention of recognition in the title and abstract (this restricted number to n=50).

Based on these criteria we identified 44 studies for screening on full text. Full texts were again reviewed for relevance and research design. Following full text screening, 19 studies were included.

Included papers were critically appraised using tools agreed by NICE and data extracted using a coding set developed to reflect the review questions. See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence

1. Children, young people and adult survivors' experiences of recognising and disclosing their own abuse

Description of evidence

We found 10 UK studies which examined the experiences of children, young people and adult survivors of child abuse in recognising their own abuse and disclosing it to others. The characteristics of the studies are shown in Table 7.

Table 7. Description of evidence – children, young people and adult survivors' experiences of recognising and disclosing their own abuse

Author/date	Study methods	Quality rating and reason (for studies rated as poor)	Age range of participants	Type of abuse
Allnock and Miller (2013)	Qualitative interviews with 60 young people (Surveys also carried out but data not reported here)	++	18-24	Sexual abuse
Beckett et al. (2013)	Individual interviews with 150 young people Eight single sex focus groups with 38 young people (plus 11 focus groups with 76 professionals)	++	13-28	Gang-associated sexual violence and exploitation
Children's Commissioner. (2015)	Survey of 756 survivors of child sexual abuse Focus groups with 5 victim/survivor organisations	- Little methodological information provided, particularly regarding survey distribution, response rates and representativeness of resulting sample. Limited	Over 18	Sexual abuse

		consideration of ethical issues in reporting		
Cossar et al. (2013)	Content analysis of an online peer support website (261 threads) Interviews with 30 vulnerable young people Focus groups with children and young people (data not reported here as do not meet our population criteria), parents and practitioners	++	10-20	Appears to cover all forms of abuse
Coy (2009)	Autobiographical interviews with 14 adult survivors of abuse	+	17-33	Child sexual exploitation
Liao et al. (2013)	Interviews with 17 Somali-speaking women	- Lack of information regarding where FGM was conducted is a significant omission in terms of us being able to draw conclusions from this study relevant to our review	Adults – ages not reported	Female genital mutilation
McElvaney et al. (2014)	In-depth semi-structured qualitative interviews were conducted with 22 young people who had experienced child sexual abuse and 14 parents of these young people	++	7-18	Sexual abuse
NSPCC (2013)	Five focus groups attended by a total of 26 people who had	- No consideration of ethical issues	Assume over 18, although not reported	Abused by Jimmy Savile

	been abused by Jimmy Savile	reported. Little consideration of transferability of the findings to other cases of abuse, given the particular circumstances (i.e. high profile celebrity case). Little detail given regarding participants, or methods of analysis		
Rees et al. (2010)	Interviews with 24 young people who had been referred to children's social care	+	11-18 Includes 5 unaccompanied asylum-seeking children	Appears to cover all forms of abuse
Stanley et al. (2012)	Five focus groups with 19 young people (Also interviews 11 survivors and 10 perpetrators)	+	10-19	Witnessing domestic violence

Narrative summary

The study by Cossar et al. (2013 ++) employs a useful framework, which distinguishes between:

- recognition – by young people that they are being abused
- telling – young people disclosing the abuse to another person, which is split in to 4 further categories: remaining hidden, coming to the attention of others through signs and symptoms, prompted telling and purposeful telling
- help – response to telling can result in various forms of help.

This framework has guided the thematic analysis of the papers, which is divided into the broad areas of 'recognition' and 'telling' or disclosure. ('Help' is more relevant to our review question on response.)

Young people's experiences of recognising their own abuse

Five of the studies (Allnock and Miller 2013 ++; Beckett et al. 2013 ++; Children's Commissioner 2015 -; Cossar et al. 2013 ++; NSPCC 2013 -) found that both young people and adult survivors reported they had not realised that what they were experiencing was abuse. Allnock and Miller (2013 ++) and Cossar et al. (2013 ++) note that this can be related to developmental stage, and that older children can be more likely to recognise their experiences as abusive. The study by the Children's Commissioner (2015 -) found that 26% of the respondents to the survey did not realise that they were being abused until they reached adulthood.

The most detailed exploration of the issue of recognition is reported in Cossar et al.'s analysis of internet forum threads, which identifies the following barriers to recognition:

- The young person feeling that they deserved it. One young person posted: "I believe every word said by my mum that I'm no good, that I'm useless, that I've done everything wrong" (p37).
- A difficulty in acknowledging that a parent could be abusive.
- A parent's unpredictability when abuse was episodic, and relationship was sometimes good.
- Confusion about the boundaries between discipline and physical abuse.
- Confusion about boundaries relating to touching with family members. One young person posted about a male member of the family who made her feel uncomfortable because he wanted her to sit on his lap: "He might be just showing affection and I don't want to make a big deal out of it if I've got it all wrong, but it does make me feel really uncomfortable." (p.39).

Cossar et al. also note that:

- young people may actively dismiss the definition of an experience as 'abuse', for example in the context of sexual relationships between peers or as a coping mechanism
- recognition may not be a clear-cut issue, but may be a gradual realisation over time, as the young person gets older.

In the Beckett et al. (2013 ++) study of gang-associated sexual violence and exploitation, young people also reported that abusive experiences were part of 'normal' life for them. One young person said: "I'm used to it … its normal … Welcome to our generation" (p43).

None of the studies discussed ways in which young people could be supported to recognise that what was happening to them was abusive, although 1 study (Children's Commissioner 2015 -) noted that seeing coverage in the media was a prompt to understanding for some survivors of abuse.

Young people's experiences of telling

'Remaining hidden' and barriers to disclosure

One retrospective study with adult survivors (Children's Commissioner 2015 -) found that a relatively large proportion (43%) of participants in the research did not tell anyone about the abuse at all. Seven studies (Allnock and Miller 2013 ++; Beckett et al. 2013 ++; Children's Commissioner 2015 -; Cossar et al. 2013 ++; McElvaney et al. 2014 ++; NSPCC 2013 -; Rees et al. 2010 +) discussed barriers to disclosure by young people. A summary of the barriers is shown in Table 8.

Table 8. Barriers to disclosure

Barrier	Description	Allnock and Miller (2013 ++)	Beckett et al. (2013 ++)	Children's Commissioner (2015 -)	Cossar et al. (2013 ++)	McElvaney et al. (2014 ++)	NSPCC (2013 -)	Rees et al. (2010 +)
Emotional barriers and anxieties	Including fear of not being believed, shame, embarrassment, self-blame, worried that situation 'not serious enough' to tell	✓	✓	✓	✓	✓	✓	✓
Fear of retaliation or consequences	Included worries about impact on family and other siblings, fear of being put in to care, fear of being seen as a 'grass' (relates to Beckett et al. 2013 specifically)		✓	✓	✓	✓		✓
Did not know who to turn to	Included isolation, or not being aware of what professionals would be able to help	✓					✓	✓
Not 'having the right words'	Not knowing how to tell, or having the right vocabulary to describe experiences	✓		✓	✓			
Perpetrator tactics	Threats by abuser, or perpetrator manipulating others into believing that child is to blame	✓			✓			
No one listened, asked or noticed	Young person tried to ask for help but was not listened to, or changes in their behaviour were not noticed	✓			✓			

Anxiety about confidentiality	Worried that information would not be kept confidential	✓			✓			
Lack of faith in services' ability to protect	Mistrust of services, e.g. due to perceived lack of convictions by police of perpetrators		✓	✓				
Professional environments intimidating	Can be difficult to disclose to professionals in a 'professional environment'			✓				

Six studies identified factors that supported young people to disclose abuse. These included:

- a supportive and trusted relationship with a professional, built up over time (Cossar et al. 2013 ++; Rees et al. 2010 +) and being listened to and validated (Stanley et al. 2012 +)
- being asked, with the person asking being persistent if needed (Allnock and Miller 2013 ++; Cossar et al. 2013++; McElvaney et al. 2014 ++)
- being in a 'safe space' where the young person is protected from their abuser (Children's Commissioner 2015 -).

One study of adult survivors reported that participants thought that more accessible services (for example, police stations based in the community) would promote disclosure (NSPCC 2013 -).

Coming to the attention of others through signs and symptoms and prompted telling

Five studies (Allnock and Miller 2013 ++; Children's Commissioner 2015 -; Cossar et al. 2013++; McElvaney et al. 2014 ++; NSPCC 2013 -) noted that young people who do not disclose directly may be communicating through their demeanour and behaviour. Examples of behaviours given included self-harming or not eating (McElvaney et al. 2014 ++), drug and alcohol misuse, risk-taking behaviours, running away, antisocial behaviour and poor relationships with parents and carers (NSPCC 2013 -).

In 3 studies (Allnock and Miller 2013 ++; Cossar et al. 2013 ++; McElvaney et al. 2014 ++), young people reported that it was a professional enquiring about their behaviour, or a change in their behaviour/demeanour that had prompted them to disclose the abuse.

Purposeful telling – who do young people disclose to?

Four studies (Children's Commissioner 2015-; Cossar et al. 2013++; McElvaney et al. 2014++; Rees et al. 2010+) looked at who young people chose to disclose to. One study with adult survivors (Children's Commissioner 2015 -) found that a relatively large proportion (43%) of participants in their research did not tell anyone about the abuse at all. Of those who did tell someone, the most frequent people they

told were their mother (n=102), a friend/peer (n=85), or a teacher (n=51). Similarly, Cossar et al.'s (2013 ++) interviews with young people found that, of the informal sources of support available to them, young people were most likely to tell a parent if their aim was 'stopping the abuse'. Two studies (McElvaney et al. 2014++; Rees et al. 2010 +) highlighted the important role that disclosure to peers can play, including being a 'first step' to disclosing to a professional (McElvaney et al. 2014 ++).

In relation specifically to disclosing to professionals, Cossar et al. (2013 ++) found that, in interviews, young people highlighted different professionals that they would speak to depending on what outcome they wanted:

- stopping the abuse – young people were more likely to cite the police (23 mentions), social workers (21 mentions) and teachers (15 mentions)
- information and advice – young people were most likely to mention teachers (10 mentions), helplines (9 mentions), youth workers (7 mentions) or friends (8 mentions)
- emotional support – the professionals most likely to be mentioned were CAMHS (13 mentions) or youth workers (10 mentions)
- practical strategies to minimise harm – young people most often mentioned teachers (6 mentions), CAMHS workers (5 mentions), youth workers (4 mentions)
- medical help – doctors were most frequently mentioned (14 mentions) and school nurses (8 mentions) were perceived as having a wider role for emotional support as well as medical help.

Experiences of disclosing to professionals

Three studies explored specifically young people's experiences of telling professionals in education, children's social care or the police (Allnock and Miller 2013 ++; NSPCC 2013-; Rees et al. 2010 +).

Young people reported mixed experiences of telling education professionals (Allnock and Miller 2013 ++). Positive experiences included being believed and the abuse being reported through the correct channel. Negative experiences of disclosing to teachers were characterised by the teachers' failure to inform the young person of how the disclosure would be handled, or of going to their parents.

Experiences of disclosing to the police tended to be more negative (Allnock and Miller 2013 ++; Rees et al. 2010+) and in 1 study young people reported experiencing the police as 'dismissive' (Rees et al. 2010 +). However, of the 5 unaccompanied asylum-seeking children in this study, 4 reported that they had positive experiences in dealing with the police via interpreters (Rees et al. 2010 +). In relation to children's social care, in 1 study young people noted that their family had already been involved with the service, and so there was a missed opportunity to identify the abuse that was taking place (Allnock and Miller 2013 ++).

One study involving adult survivors (Tucker 2011 ++) looked in particular at instances where young people thought they had not been believed. Four key reasons were identified for this:

- the history and 'baggage' of the young person influencing professional perceptions (for example, having a criminal record)
- not being believed due to their family background
- professionals being reluctant to believe them and practising 'defensively'
- the relationship between the young person and their abuser, and perceptions that the abuser couldn't have acted in that way.

Adult survivors' experience of child sexual exploitation

We found 1 moderate quality UK study (Coy 2009 +) examining the experiences of 14 adult survivors of child sexual exploitation who had been looked after.

The study reports the adult survivors' experiences of being in care, and how this linked with them becoming sexually exploited (the study terms this as 'entry into prostitution', although it is clear that some participants were still children when they began to be exploited).

Participants in the study highlight the multiple placement moves they experienced while in the care system, over which they had little say or control, as a key factor in becoming sexually exploited due to:

- not being able to form attachments with adult professionals, leaving them open to forming attachments to 'predatory' older men and people 'embedded in the street prostitution community' (p262)

- experiences of trying to fit in at each new place led to a tendency to seek approval of others, which left people vulnerable to exploitation
- seeking control through gaining financial stability via prostitution.

Adult survivors' experiences of female genital mutilation

We found 1 poor quality UK study (Liao et al. 2013 -) which asked 17 adult women about their experiences of female genital mutilation (FGM). All women were Somali-speaking. It should be noted that the study does not make clear where the FGM was carried out.

The study found that none of the women had consented to FGM. The most common person who had wanted them to have FGM was their mother (8/17 participants). Eight of the 17 women reported that the procedure had been painful. Seven reported ongoing physical health problems, 4 reported sexual difficulties, 2 reported fear of men and 4 reported emotional or family problems.

2. Caregiver experiences of disclosing child abuse

Description of evidence

We found 2 studies (Gilligan and Akhtar 2006 -; Stanley et al. 2012 +) which looked at caregivers' experiences of disclosing child abuse. Gilligan and Akhtar (2006 -) explored the views of 130 Asian women in Bradford in relation to disclosing and getting help for child sexual abuse. The paper has been rated as poor because the aims of the research are somewhat unclear, with little information on sampling and methods. The study also appears to bring in other sources of information such as practitioner data, which are not fully described in the methodology.

Stanley et al. (2012 +) aimed to explore both domestic violence survivors' (n=11) and perpetrators' (n=10) experiences of domestic violence in families with children through qualitative interviews. Of relevance to this review question were aspects of the research related to disclosing and acknowledging domestic violence.

Narrative summary

Gilligan and Akhtar (2006 -) explored 'cultural imperatives arising from concepts such as izzat (honour-respect), haya (modesty) and sharam

(shame/embarrassment)' (p1367). The study notes that, in many Asian communities, these cultural imperatives appear to make it even more difficult to disclose sexual abuse. The study also reports that these considerations can mean that despite professional attempts at 'confidentiality', victims and non-abusing parents may feel that the disclosure of sexual abuse is a public event. One participant said: 'If you've got white social workers turning up at the door all the time ... it's really hard then to keep it within that family to deal with it because the word kind of gets out in a community and you have to start explaining what's going on' (p1368).

The study suggests that professionals must, therefore, take full account of such issues both in designing services and in responding to service users. This included talking with families about what would happen if they did disclose and about the processes involved.

Stanley et al. (2012 +) found that there was variation among both survivors and perpetrators of domestic violence of the extent to which they acknowledged the harm to their children. Some felt that children had been protected from the violence, whereas others recognised that their children had witnessed domestic violence. Survivors of domestic violence identified that barriers to disclosing domestic violence included stigma and shame, and disbelief by professionals, which hindered them from wanting to disclose again. Perpetrators of domestic violence reported that identifying harm to children could be supported by non-judgemental attitudes from professionals.

3. Practitioner views of what helps and hinders recognition

Description of evidence

We found 8 studies which sought practitioner views of what helps and hinders recognition of child abuse. The characteristics of the studies are shown in Table 9.

Table 9. Description of evidence – practitioner views of what helps and hinders recognition

Author/date	Study methods	Quality rating and reason (for poor studies)	Type of abuse
Burgess et al. (2012)	12 focus groups with 114 practitioners	-	Child neglect

		Little information regarding methodology. Difficulty in identifying or contextualising who said what. There is no consideration of limitations or theory underpinning focus groups	
Cossar et al. (2013)	Focus groups with 16 practitioners (also content analysis of an online peer support, interviews with 30 vulnerable young people)	++	Appears to cover all forms of abuse
Daniel et al. (2010)	Systematic review	- Extensive systematic search, however little in-formation given about individual included studies, and method for synthesising study findings very unclear	Child neglect
Harper and Scott (2005)	Qualitative interviews with 90 professionals	+	Child sexual exploitation, with small amount of information in relation to trafficking
Kazimirski et al. (2009)	In-depth interviews with 40 professionals across 4 case study local authorities	+	Forced marriage
McNaughton Nicholls et al. (2014)	Qualitative research with 50 professionals (41 interviews and 9 online responses)	+	Child sexual exploitation
Pearce et al. (2009)	Qualitative interviews with 72 practitioners and review of case files of 37 trafficked children	++	Child trafficking
Rigby (2011)	Qualitative data gathered from 16	-	Child trafficking

	experienced frontline professionals via 7 individual interviews, and 2 focus groups	Not clear which data were gathered via interview, and which via focus group. There is also relatively little presentation of primary data in the study report	

Three studies examined professional practice in relation to neglect and non-specified forms of child abuse. These were 1 poor quality systematic review (Daniel et al. 2010 -), 1 poor quality qualitative study (Burgess et al. 2012 -) and 1 good quality qualitative study (Cossar et al. 2013 ++).

Two moderate quality qualitative studies examined professional practice in relation to child sexual exploitation (Harper and Scott 2005 +; McNaughton Nicholls et al. 2014 +). It should be noted that the Harper and Scott study, though of relatively good quality, is somewhat dated, and it is likely that professional practice will have changed since 2005. McNaughton Nicholls et al. (2014 +) were specifically considering the sexual exploitation of boys and men.

Two studies explored professional practice in relation to child trafficking, 1 good quality (Pearce et al. 2009 ++) and 1 poor quality (Rigby 2011 -). One moderate quality study explored professional practice in relation to forced marriage (Kazimirski 2009 +).

Narrative summary

Neglect and non-specified forms of abuse

The 3 studies examining practice in relation to neglect and non-specified forms of child abuse all had relatively sparse findings in relation to what helps and hinders recognition of different forms of maltreatment.

The systematic review of practice in relation to neglect by Daniel et al. (2010 -) cited 5 studies (Appleton 1996; Bryant and Milsom 2005; Lewin and Herron 2007; Paavilainen et al. 2002; Rose and Meezan 1995, 1996, cited in Daniel et al. 2010 -) which looked at the role of different professionals in identifying neglect. The review concludes that 1 study (Rose and Meezan 1995), which found that mothers are

generally shown to express greater concerns about maltreatment than professionals in the UK and USA, suggests that 'the general population is at least as well-equipped as professionals to recognize aspects of neglectful care, if not more so' (p252). The studies also highlight the role of those working in health and education in recognising neglect. What helps and hinders recognition is not discussed – this study has therefore not contributed to an evidence statement.

Participants in Burgess et al.'s (2012 -) study suggested that the following aspects of practice hinder recognition of neglect:

- the fact that neglect can be less 'clear cut' than other forms of abuse
- that neglect may be masked by children's resilience and ability to cope
- that recognition can be hindered by lack of resources and high caseloads, meaning that there is less time to spend with families.

Cossar et al.'s (2013 ++) focus group with practitioners highlighted the importance of practitioners noticing abuse, and asking questions of young people, rather than waiting for them to disclose abuse.

Child sexual exploitation (CSE)

Harper and Scott (2005 +) reported that professionals identified the following barriers to recognising and identifying CSE:

- police being restricted in the amount of proactive work they can do, and children's social care receiving few referrals directly about child sexual exploitation (note, this may well have changed since 2005)
- professionals reluctant to identify as few services in place once CSE identified
- health professionals can struggle with issues of confidentiality
- overall atmosphere within schools, for example, homophobic bullying, can prevent disclosure/identification.

McNaughton Nicholls et al. (2005 +) reported professionals' perceptions of why boys and young men may not disclose sexual exploitation. Some of the general barriers to disclosure mirrored many of the views of young people in section 1, and included a lack of recognition, in part due to the grooming process by perpetrators; fear of losing the 'benefits' of the exploitation relationships; fear of not being believed, or

people thinking they had consent to sex; and fear of retaliation by perpetrators. Professionals also identified that boys and young men may have specific barriers to disclosure such as fear of homophobia from professionals and difficulty in identifying themselves as victims. Professionals also thought that trans young people would particularly fear disclosing abuse, because their gender identity might be seen as a reason for the abuse.

The study also reports the following barriers in relation to professional practice, with regard to identifying the sexual exploitation of boys and young men:

- discriminatory social attitudes and stereotypes, including poor understanding of sexual identities; belief that young men do not need protecting; boys and young men viewed as offenders
- gendered implementation of identification practice – for example, boys may tend to score lower on risk assessments, services tend to view boys more as offenders and focus on criminal behaviour
- gender stereotypes – indicators of CSE may be seen to apply more readily to girls than boys.

Professionals reported 3 forms of practice which they thought were effective in improving identification of boys and young men at risk of CSE:

- gender-neutral educational materials
- providing training for professionals on male victims
- co-location of CSE specialist practitioners with statutory agencies.

Child trafficking

Both of the studies exploring child trafficking (Pearce et al. 2009 ++; Rigby 2011 -) explored what professionals thought the barriers might be to children disclosing that they had been trafficked. Both studies identified that young people may not see themselves as having been trafficked, and also the significance of an ongoing relationship with the trafficker, which may include threats and intimidation. Furthermore, Pearce et al. (2009 ++) note that it may be more difficult for boys and men to disclose, and Rigby (2011 -) that young people are likely to be suffering trauma and fear which may make them reluctant to disclose. In terms of what may

support disclosure, both studies note the importance of a trusting working relationship.

Both studies also look at what aspects of professionals' mindset and practice may hinder them from identifying child trafficking. Both studies noted that children and young people's accounts of trafficking can be disjointed and therefore difficult to corroborate. Rigby (2011 -) also notes that identification can be impeded by a lack of awareness of the issue of trafficking and a lack of understanding of other cultures.

Pearce et al. (2009 ++) also note the following factors that can promote identification:

- not allowing age or immigration status concerns can override child protection concerns, which should be paramount
- not assuming that an interpreter from the same community is the best choice, when in fact they may represent to the child the community which has exploited to them
- having continuity with the same interpreter, keyworker or legal guardian
- use of an independent guardian
- not allowing the image of trafficking for sexual exploitation to overshadow awareness of the other forms of exploitation, including benefit fraud, forced marriage, domestic servitude or work in cannabis factories or nail parlours
- remembering that children who are originally from the UK can be trafficked, and that both girls and boys can be trafficked.

Forced marriage

The study examining professional practice in relation to forced marriage (Kazimirski et al. 2009 +) identified the following factors that could prevent detection of forced marriage:

- a perception among statutory services that the issue is of low prevalence
- working with 'hard to reach' communities who may have low levels of trust in statutory services, and in which it can be difficult to get young women to attend appointments in an office environment, or to gain access to the family home
- identification of forced marriage may not be a priority in the context of 'stretched' children's services (p38)

- lack of professional understanding of forced marriage, and how it differs from arranged marriage
- language barriers and lack of access to interpretation services
- lack of accessible reporting sites for young people.

The study identifies the following factors that facilitate detection:

- perception of forced marriage as a clear abuse of young people's right to choose who they marry
- empowerment of young people through information about their rights
- raising awareness of forced marriage among teachers, learning mentors and personal advisors
- multi-agency forced marriage training
- information-sharing protocols between agencies, for example, between police and domestic violence teams
- using direct methods of communication with young people, for example via text message.

Economics

No economic analysis or modelling was undertaken for this review question.

Evidence statements

ES139	**ES139. Children, young people and adult survivors' experiences of recognising their own abuse** There is a moderate amount of evidence of mixed quality comprising 3 good quality UK qualitative studies (Allnock and Miller 2013 ++; Beckett et al. 2013++; Cossar et al. 2013 ++) and 2 poor quality UK qualitative studies (Children's Commissioner 2015 -; NSPCC 2013 -) that children and young people do not always recognise their own experiences as abusive.
ES140	**ES140. Children, young people and adult survivors' experiences of barriers and facilitators of disclosing abuse** There is a good amount of evidence of mixed quality comprising 4 good quality UK qualitative studies (Allnock and Miller 2013 ++; Beckett et al. 2013; Cossar et al. 2013 ++; McElvaney et al. 2014 ++), 1 moderate quality UK study (Rees et al. 2010 +) and 2 poor quality UK qualitative studies (Children's Commissioner 2015 -; NSPCC 2013 -) that there are a range of barriers to young people disclosing abuse. These include emotional barriers; fear of retaliation and consequences, and that their information may be shared; not knowing who to turn to, and no one asking them.

	Factors which facilitate young people to disclose abuse include a supportive and trusting relationship with a professional; being asked, with the person asking being persistent if needed; and being in a 'safe space'.
ES141	**ES141. Children, young people and adult survivors' experiences of communicating abuse via their behaviour** There is a moderate amount of evidence of mixed quality comprising 3 good quality UK qualitative studies (Allnock and Miller 2013 ++; Cossar et al. 2013 ++; McElvaney et al. 2014 ++) and 2 poor quality UK qualitative studies (Children's Commissioner 2015 -; NSPCC 2013 -) that young people who do not disclose abuse directly may communicate through their demeanour and behaviour.
ES142	**ES142. Children, young people and adult survivors' experiences of informal and formal disclosures of abuse** There is some evidence of mixed quality comprising 3 good quality UK qualitative studies (Cossar et al. 2013++; McElvaney et al. 2014++; Tucker et al. 2011 ++), 1 good quality UK qualitative study (Rees et al. 2010 +) and 1 poor quality UK qualitative study (Children's Commissioner 2015 -) that young people may disclose to a variety of people, depending on what outcome they are seeking to achieve. One study (Children's Commissioner 2015 -) found that adult survivors of abuse who had disclosed to someone were most likely to have told their mother, a friend or peer, or a teacher.
ES143	**ES143. AMENDED Children, young people and adult survivors' experiences of disclosing abuse to professionals** There is some evidence of mixed quality comprising 2 good quality UK qualitative studies (Allnock and Miller 2013 ++; Tucker 2011 ++), 1 moderate quality UK qualitative study (Rees et al. 2010 +) and 1 poor quality UK qualitative study (NSPCC 2013 -) that young people value experiences of disclosure where they feel that they are being believed; are not 'dismissed' including on the basis of their personal or family history, or due to professionals' reluctance to act; and where appropriate action is taken.
ES144	**ES144. Caregiver experiences of disclosing child sexual abuse in Asian communities** There is evidence from 1 poor quality UK qualitative study (Gilligan and Akhtar 2006 -) that there are particular barriers to caregivers disclosing child sexual abuse in Asian communities, particularly in relation to the perceived confidentiality of the information.
ES145	**ES145. Caregiver experiences of disclosing child exposure to domestic violence** There is evidence from 1 moderate quality UK qualitative study (Stanley et al. 2012 +) that adult survivors of domestic violence can be hindered from disclosing abuse by factors such as stigma and shame, and experiences of not being believed by professionals.
ES146	**ES146. Practitioner views on barriers to recognition of neglect** There is evidence from 1 poor quality UK qualitative study (Burgess et al. 2012 -) that practitioners identify the following barriers to identification of child neglect: the fact neglect may be less clear-cut than other forms of abuse; it can be masked by children's resilience; and lack of resources and high caseloads.
ES147	**ES147. Practitioner views on barriers to recognition of abuse**

	There is evidence from 1 good quality UK qualitative study (Cossar et al. 2013 ++) that practitioners think that less emphasis should be placed on waiting for young people to disclose abuse, and more on professionals noticing and asking young people about abuse.
ES148	**ES148. Practitioner views on barriers to recognition of child sexual exploitation** There is evidence from 1 moderate quality UK qualitative study (Harper and Scott 2005 +) that practitioners identify the following barriers to identification of child sexual exploitation: a lack of proactive identification work by the police and children's social care; professional reluctance to identify if services are not in place; concerns about breaching confidentiality in health services; and school environments that are not conducive to young people disclosing abuse. However, it should be noted that practice is likely to have changed since this report was conducted.
ES149	**ES149. Practitioner views on barriers to recognition of sexual exploitation of boys and young men** There is evidence from 1 moderate-quality UK qualitative study (McNaughton Nicholls et al. 2014 -) that practitioners identify the following barriers to identifying sexual exploitation in boys and young men: discriminatory attitudes among professionals; gendered implementation of identification practice; and gender stereotypes.
ES150	**ES150. Practitioner views on barriers to recognition of child trafficking** There is a small amount of evidence from 1 good quality UK qualitative study (Pearce et al. 2009 ++) and 1 poor quality UK qualitative study (Rigby 2011 -) that practitioners consider barriers to identifying child trafficking to include: young people who have been trafficked not being aware of, or disclosing, their abuse and young people's accounts being fragmented. One study (Rigby 2011 -) also notes that identification can be impeded by a lack of awareness of the issue of trafficking and a lack of understanding of other cultures. One study (Pearce et al. 2009 ++) notes that identification can be promoted by ensuring child protection concerns are paramount; continuity of interpreters who are not necessarily from the same community; use of an independent guardian; and awareness of all forms of trafficking, including internal trafficking.
ES151	**ES151. Practitioner views on what helps and hinders recognition of forced marriage** There is evidence from 1 moderate quality UK qualitative study (Kazimirski et al. 2009 +) that practitioners perceive the following to be barriers to recognising forced marriage: a lack of understanding of the issue and low priority in the context of stretched services; working with 'hard to reach' communities who may have low levels of trust in statutory services; language barriers and lack of access to interpretation services; and lack of accessible reporting sites for young people. Practitioners perceive the following to facilitate recognition: understanding of the issue, including awareness-raising and multi-agency training; information-sharing between agencies; empowerment of young people; and direct communication with young people.
ES183	**ES183. Adult survivor views on the link between frequent care placement moves and child sexual exploitation** There is evidence from 1 moderate quality UK qualitative study (Coy 2009 +) that adult survivors of child sexual exploitation report a link between

	multiple placement moves while in care and becoming a victim of child sexual exploitation.
ES184	**ES184. Adult survivor views on female genital mutilation** There is evidence from 1 poor UK qualitative study (Liao et al. 2013 -) that adult survivors of female genital mutilation report that they had not consented to the procedure, and that a substantial proportion report ongoing physical, mental and emotional difficulties.

Included studies for these review questions

Allnock D and Miller P (2013) No one noticed, no one heard: a study of disclosures of childhood abuse. London: NSPCC

Beckett H, Brodie I, Factor F et al. (2013) 'It's wrong … but you get used to it' – a qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England. London: Office of the Children's Commissioner for England

Burgess C, Daniel B, Scott J et al. (2012) Child neglect in 2011: an annual review by Action for Children in partnership with the University of Stirling. Watford: Action for Children

Children's Commissioner (2015) Protecting children from harm: a critical assessment of child sexual abuse in the family network in England and priorities for action. London: Office of the Children's Commissioner for England

Cossar J, Brandon M, Bailey S et al. (2013) 'It takes a lot to build trust' – recognition and telling: developing earlier routes to help for children and young people. London: Office of Children's Commissioner

Coy M (2009) Moved around like bags of rubbish nobody wants: how multiple placement moves can make young women vulnerable to sexual exploitation. Child Abuse Review 18: 254-66

Daniel B, Taylor J and Scott J (2010) Recognition of neglect and early response: overview of a systematic review of the literature. Child and Family Social Work 15: 248-57

Gilligan P and Akhtar S (2006) Cultural barriers to the disclosure of child sexual abuse in Asian communities: listening to what women say. British Journal of Social Work 36: 1361-77

Harper Z and Scott S (2005) Meeting the needs of sexually exploited young people in London. London: Barnardo's

Kazimirski A, Keogh P, Kumari V et al. (2009) Forced marriage prevalence and service response. London: Natcen

Liao L M, Elliott C, Ahmed F et al. (2013) Adult recall of childhood female genital cutting and perceptions of its effects: a pilot study for service improvement and research feasibility. Journal of Obstetrics and Gynaecology 33: 292-5

McElvaney R, Greene S, Hogan D (2014) To tell or not to tell? Factors influencing young people's informal disclosures of child sexual abuse. Journal of Interpersonal Violence 29(5): 928-47

McNaughton Nicholls C, Harvey S and Paskell C (2014) Gendered perceptions: what professionals say about the sexual exploitation of boys and young men in the UK. London: Barnardo's

NSPCC (2013) Would they actually have believed me? A focus group exploration of the underreporting of crimes by Jimmy Savile. London: NSPCC

Pearce J, Hynes P, Bovarnick S (2009) Breaking the wall of silence: practitioners' responses to trafficked children and young people. London: NSPCC

Rees G, Gorin S, Jobe A et al. (2010) Safeguarding young people: responding to young people 11 to 17 who are maltreated. London: The Children's Society

Rigby P (2011) Separated and trafficked children: the challenges for child protection professionals. Child Abuse Review 20: 324-40

Stanley N, Miller P, Richardson, Foster H (2012) Engaging with children's and parents' perspectives on domestic violence. Child and Family Social Work 17: 192-201

Tucker S (2011) Listening and believing: an examination of young people's perceptions of why they are not believed by professionals when they report abuse and neglect. Children and Society 25: 458-69

3.4 Assessment of risk and need in relation to abuse and neglect – tools

Introduction to the review question

There is debate in practice regarding whether practitioner judgement in the assessment of risk and need in relation to abuse and neglect can be enhanced by the use of standardised tools. The purpose of this review question was to assess what tools are effective and cost effective in supporting practitioners to undertake assessment of children, young people and their caregivers and families when a child or young person is at risk of, experiencing or has experienced abuse or neglect. The question related to assessment of current or prospective risk and/or need in relation to child abuse and neglect.

Our searching and screening found very few studies of assessment tools which met our review protocol (that is, used a comparative design, and measured the predictive validity of the tool against an objective criterion). One of the included studies only achieved a comparative design through a 'natural experiment' arising from the fact that professionals were able to 'override' decisions made by the model (Johnson et al. 2011 -). Both of the included studies rated of poor quality: this was in part due to flaws in study design, but also due to unclear reporting of methods and statistics in both papers.

Review questions

7. What tools support effective assessment of risk and need in relation to child abuse and neglect?

Summary of the review protocol

The protocol sought to identify studies that would assess what tools are effective or cost effective in supporting practitioners to undertake assessment of children, young

people and their caregivers and families when a child or young person is at risk of, experiencing or has experienced abuse or neglect.

The original review protocol specified that we would consider only studies that:

- compared the use of particular tools with usual practice or another tool
- considered the impact of particular tools on health and wellbeing outcomes for children and families, and their acceptability to families.

During screening for this question, we amended the second of these criteria to include studies which examined the predictive validity of particular tools, that is, the extent to which the tools accurately predicted levels of risk or need, provided that this was measured using an objective measure (for example, substantiated reports to child protective services) rather than a subjective measure (for example, another risk scale).

The study designs included for these questions were: randomised or quasi-RCTs of assessment tools; impact evaluation (for example, prospective comparative evaluation); economic evaluation or systematic reviews of studies of the above design.

Full protocols can be found in Appendix A.

Population

Children and young people (under 18) who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families.

Practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families. For example, social workers, health professionals, those working in education, voluntary sector providers.

Intervention

Standardised tools to assist current or prospective assessment of risk and/or need in relation to child abuse and neglect. This may include tools developed on the basis of consensus (expert opinion about risk/likelihood of harm) or those which are empirically/statistically based. For assessment, this may include risk/safety

checklists, strengths and needs assessment tools or mapping tools (Barlow et al. 2012).

This does not include:

- tools used to assess retrospectively occurrence of child abuse and neglect (for example, survey questions intended to determine prevalence)
- tools used in clinical assessment of behaviours and conditions which may arise as a result of abuse and neglect (for example, PTSD, internalising and externalising behaviour, mental health problems)
- tools used for general assessment of parenting capacity, which do not refer specifically to abuse and neglect.

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children's own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings
- schools and colleges
- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Predictive validity of tool, acceptability to children, young people and their caregivers and families (including as reported by adult survivors of child abuse and neglect); incidence of abuse and neglect; quality of parenting and parent-child relationships, including quality of attachment, children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

We did not include studies in which reliability of the tool was the only outcome.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM)); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials registries, were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and October 2014. Update searching of the bibliographic databases searches took place in April 2016.

Summary from re-run searches

An updated search was carried out in April 2016 to identify any new studies relating to the effectiveness questions (5, 7, 9-13, 15-19) published since the original searches were conducted for this guideline. This search used the same search terms and databases as the main search.

As we originally conducted a single search for all of the original 21 questions, the search identified a large number (10,833) of items which we used as a 'database' within which to search for studies relevant to our questions. This included specific searches for interventions for which evidence had already been reviewed.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope.

Studies that were included after the initial screening stage were assigned to questions. Studies assigned to this question were then screened against the following criteria:

- country (study is not from Europe, Israel, Australia, Canada, USA, New Zealand)
- evidence type (not an empirical study comparing the use of particular tool with usual practice or another tool)
- population (population is not children and young people who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families OR practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families)
- tool type or focus (not about a standardised tool to assist assessment of risk and/or need in relation to child abuse and neglect)
- outcomes (study does not measure acceptability to children, young people and their caregivers and families, predictive validity of tool as compared to an objective measure, incidence of abuse and neglect; quality of parenting and parent-child

relationships, including quality of attachment, children and young people's health and wellbeing; parents' health and wellbeing; service outcomes).

We identified 54 potentially relevant studies based on title and abstract. After screening the full texts of these studies, 52 were excluded and 2 were included. After an update search of literature from 1 January 2014 to 30 April 2016 we identified a further 14 papers of possible relevance to this question. Following full text review using the same criteria as the previous screening process, no additional studies were included.

Included papers were critically appraised using tools agreed by NICE and data extracted using a coding set developed to reflect the review questions. See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence

Description of evidence

We found 2 poor quality prospective evaluations of risk assessment tools, both from the US (Baumann et al. 2005 -; Johnson et al. 2011 -).

The first paper (Baumann et al. 2005 -) reports 3 linked studies, 2 of which met our inclusion criteria. The first evaluated the performance of a computerised actuarial risk assessment model in predicting substantiated maltreatment at intake, and the second assessed another model's performance at the investigation stage in predicting likelihood of re-investigation.

The risk assessment model had been developed in a prior study through statistical determination of features of cases which predicted substantiation or re-investigation (actuarial tool). The 2 studies compared judgements made by the computerised model, before interpretation by staff, and between staff judgements made:

- based on a computerised version of the actuarial tool ('computer group')
- based on a paper version of the actuarial risk form ('new form group').
- according to usual practice (study 1: assessment using a paper 'checklist' of consensus-based items; study 2: departmental risk assessment instrument).

The study looks at judgements made in relation to physical abuse, sexual abuse, neglectful supervision and physical/medical neglect. The study has been rated as poor due to lack of clarity in the paper about:

- the units of analysis (whether correlations were calculated per judgement, per case, or per worker)
- how the data had been analysed, and whether reported correlations represent within- or between-group differences

There is also very scarce reporting of statistical data, with most findings shown in graphical form without accompanying statistics, significance values or effect sizes.

The second paper (Johnson et al. 2011 -) is a prospective evaluation of the California Family Risk Assessment (CFRA), focusing on the validity of the tool and its use in practice. The CFRA is an actuarial risk assessment model developed by the Children's Research Centre in the USA. CFRA comprises 2 10-item scales: 1 assesses future likelihood of physical or sexual abuse, 1 assesses future likelihood of neglect. Scales result in a score of low, moderate, high or very high risk. The highest score on either scale forms the basis for decisions about what services are provided. The results of the CFRA are used to decide whether to provide 'in-home' child protection services and the intensity of support provided.

The main study validates the instrument on a sample of 6543 cases. However, this was a non-comparative design and so not eligible for this review question. However, 1 element of the study compares the predictive validity of the CFRA with clinical judgements made by workers when they chose to 'override' the CFRA scores (n=114), thereby introducing a comparative element. When workers choose to override the CFRA scores, this can take the following forms: 1) a 1-category increase when the workers' impressions suggest that the case is higher risk than CFRA indicates and 2) changing the category to 'very high risk' in the presence of particular indicators (indicators not reported).

The study was rated as poor because the comparative element is the result of a 'natural experiment' occurring when practitioners choose to override the result of the CFRA, rather than a systematic comparison of practitioner judgements and CFRA. This is a relatively weak study design: ideally, cases should have been assigned

ratings using CFRA or practitioner judgements by 2 different individuals. Also, potential influence on risk of follow-up intervention is reported to have been statistically controlled for, using logistic regression. However, the numbers of families receiving or not receiving intervention is not reported, making it difficult to judge whether this statistical adjustment is valid.

Narrative summary

The results of the Baumann et al. (2005 -) study are somewhat unclear, particularly as the main presentation of results is as graphs, without reporting associated data. The authors report that, in study 1, case workers using a paper version of the actuarial risk assessment form ('new form' group) showed:

- marginally significantly better judgements in predicting substantiated maltreatment than those using the computerised form in relation to neglectful supervision (statistical data unclear) and
- significantly better than the computer group for judgements in relation to sexual abuse (statistical data unclear).

The relative performance of the other groups is not clear. The authors interpret this as suggesting that the 'new form' group may have 'engaged a level of judgement not routinely used' (p374). For study 2, graphical presentation of results suggest that the 'new form' group appeared to show the best predictive judgements in relation to re-investigation: case worker judgements in the 'new form' group were significantly correlated with re-investigation for all types of abuse (no statistical data reported), which was not the case for the other groups. However, no direct statistical comparisons of the 3 groups are reported.

Johnson et al. (2011 -) found that, when controlling for whether families received post-investigation services, CFRA 'high' risk scores showed good predictive validity, with families rated as high risk having higher rates of substantiated maltreatment incidents within 2 years of assessment than those rated as 'low' risk (OR=6.3, 95% CI=1.15 to 34.78). However, the 'moderate' risk scores did not show good predictive validity, with no statistically significant difference in rates of substantiated maltreated incidents within 2 years of assessment compared to those rated as 'low' risk (OR=1.2, 95% CI 0.22 to 6.50). Clinical judgements made by workers did not show

predictive validity. That is, those placed in the high risk group according to clinical judgement were not significantly more likely to have substantiated incidents of maltreatment than those in the low/moderate group (OR=1.16, 95% CI 0.16 to 8.28). Likewise, those in placed in the very high risk group according to clinical judgement were not significantly more likely to have substantiated incidents of maltreatment than those in the low/moderate group (OR=1.21, 95% CI 0.24 to 6.23). There does not appear to be a direct statistical comparison of the 2 groups.

Economics

No economic analysis or modelling was undertaken for this review question.

Evidence statements

ES124	**ES124. Predictive validity of a computerised actuarial risk assessment** The evidence from 1 poor quality prospective US evaluation (Baumann et al. 2005 -), assessing the predictive validity of worker judgements based on a computerised actuarial form compared to those using a paper version of the form or usual practice, is of insufficient quality to draw any reliable conclusions.
ES125	**ES125. Predictive validity of the California Family Risk Assessment (CFRA)** The evidence from 1 poor quality prospective US evaluation (Johnson et al. 2011 -), assessing the CFRA compared to 'clinical judgement', is of insufficient quality to draw any reliable conclusions.

Included studies for these review questions

Baumann DJ, Law JR, Sheets J et al. (2005) Evaluating the effectiveness of actuarial risk assessment models. Children and Youth Services Review 27(5): 465-90

Johnson WL (2011) The validity and utility of the California Family Risk Assessment under practice conditions in the field: a prospective study. Child Abuse and Neglect 35: 18-28

3.5 Assessment of risk and need in relation to abuse and neglect – aspects of professional practice

Introduction to the review question

The purpose of this review question was to identify what aspects of professional practice help and hinder effective assessment of children, young people and their families when a child or young person is at risk of, experiencing or has experienced abuse or neglect. We specified that this should be about the assessment of risk and need in relation to abuse and neglect to distinguish this from other types of assessment. The concept of 'aspects of professional practice' was defined as including issues such as professionals' knowledge, attitudes and beliefs about abuse and neglect, and common errors of professional reasoning.

This question was intended to complement question 7, which relates to standardised tools to support recognition, by examining more general ways of working and approaches which may help and hinder recognition. The question also used relevant data from questions on views and experiences of children, young people, adult survivors of abuse, parents, carers and practitioners (questions 1 and 2).

Study quality for this question was mixed. It should be noted that a number of the papers included were not conceived of as research studies as such but had been undertaken as part of inspection or analyses of SCR data – this helps to explain why not all studies were rated highly using our critical appraisal checklists, given that our checklists are aimed predominantly at evaluating the quality of peer-reviewed research papers. Some studies had been commissioned specifically to inform policy development in particular localities and had taken fairly wide-ranging approaches to their data collection, but with little detailed description in their reports as to what each strand of data collection had found. These papers tended to focus on overall 'messages' rather than detailed reporting of research findings.

Review questions

8. What aspects of professional practice support and hinder effective assessment of risk and need in relation to child abuse and neglect?

Question 8 also included material relevant to the following questions:

1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

Summary of the review protocol

The protocol sought to pinpoint studies that would identify what aspects of professional practice support and hinder assessment of risk and need in relation to abuse and neglect. The views and experiences of children, young people, parents and carers (question 1) and practitioners (question 2) were analysed as part of this question where relevant.

The study designs included for question 8 were process evaluation, ethnographic and observational studies of practice, analyses of serious case review data and systematic reviews of these. Study designs included for questions 1 and 2 were qualitative studies, qualitative components of effectiveness and mixed methods studies, survey studies and systematic reviews of these studies.

Population

For question 8:

Children and young people (under 18) who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families.

Practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families. For example social workers, health professionals, those working in education, voluntary sector providers.

For question 1:

- children and young people (under 18) who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families
- adults over the age of 18 who experienced abuse or neglect as children reporting their childhood experiences.

For question 2:

- practitioners working with children and young people at risk of, experiencing, or who have experienced abuse and neglect, and/or their caregivers and families. For example social workers, health professionals, those working in education, voluntary sector providers.

Intervention

Assessment of risk and need in relation to abuse and neglect. In England, this could include early help assessment, or assessment under the Children Act 1989.

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children's own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings
- schools and colleges
- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Acceptability to children, young people and their caregivers and families (including as reported by adult survivors of child abuse and neglect); incidence of abuse and

neglect; quality of parenting and parent-child relationships, including quality of attachment, children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM)); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials registries were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and

October 2014. Update searching of the bibliographic databases searches took place in April 2016.

Summary from re-run searches

An updated search was carried out in April 2016 to identify any new studies relating to the effectiveness questions (5, 7, 9-13, 15-19) published since the original searches were conducted for this guideline. This search used the same search terms and databases as the main search.

As we originally conducted a single search for all of the original 21 questions, the search identified a large number (10,833) of items which we used as a 'database' within which to search for studies relevant to our questions. This included specific searches for interventions for which evidence had already been reviewed.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs. Outputs were initially screened against an exclusion tool informed by the overall parameters of the scope.

Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific criteria for those questions. For question 8 these were as follows:

- country (study is not from Europe, Israel, Australia, Canada, USA, New Zealand)
- evidence (not an empirical study including process evaluation, ethnographic and observational studies of practice, analysis of serious case review data)
- population (not an empirical study including process evaluation, ethnographic and observational studies of practice, analyses of serious case review data)
- topic (study does not relate to identifying what aspects of professional practice help and hinder effective assessment of children, young people and their families when a child or young person is at risk of, experiencing or has experienced abuse or neglect).

For questions 1 and 2 these were as follows:

- country (study is not from the UK)
- evidence (not an empirical study including qualitative studies, qualitative components of effectiveness and mixed methods studies, survey studies or systematic reviews of these study types)
- population (population is not children and young people who are at risk of, are experiencing, or have experienced abuse or neglect; their caregivers and families; adult survivors of abuse or neglect; practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families)
- topic (study does not relate to the process of recognising abuse and/or neglect, the process of assessment, services providing early help, services providing intervention following abuse or neglect).

We identified 144 potentially relevant studies based on title and abstract. Given the high volume of potentially relevant studies, a decision was taken to focus full text screening on studies conducted in the UK and the Republic of Ireland, of which there were 87. Following full text screening, we identified 12 studies which met our inclusion criteria.

See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence

1. General aspects of professional practice

Description of evidence

We found 9 UK studies which included information on aspects of professional practice which help and hinder assessment. A summary of study characteristics is given in Table 10.

Table 10. Studies containing information about general aspects of professional practice in relation to assessment

Authors, study type, quality rating, explanation if -	Study aim	Study population/data source	Type of assessment
Brandon et al. (2008) SCR synthesis, +	Study has a series of objectives 1 of which is to "… identify any lessons for policy and practice, including examples of good practice …" (p15) – this is considered to be relevant to question 8	SCR reports relating to children and young people who have died or been seriously harmed	Unclear/statutory
Cleaver and Walker (2004) Qualitative study, - Limited methodological details on postal questionnaires and interviews	To evaluate the implementation of the Framework for the Assessment of Children in Need and their Families. To explore impact of the Assessment Framework on practice	Practitioners Parents Children and young people	Statutory
Devaney et al. (2013) SCR synthesis, +	The aim of the report is to 'present key learning from the first 24 case management reviews commissioned and completed [in Northern Ireland]' (p17).	SCR reports relating to children and young people who have died or been seriously harmed	Unclear whether statutory assessment
Horwath (2005) Qualitative study, +	To establish how social workers assess cases of child neglect and to explore with the practitioners and their managers both their perceptions of their practice and factors that impact on practice	Practitioners and managers	Unclear whether statutory assessment
Ofsted (2014) Thematic inspection of 11 local authority areas, - Limited reporting of data collection methods	To explore the effectiveness of arrangements to safeguard children who experience neglect, with a particular focus on children aged 10 years and under	Parents Practitioners	Statutory
Platt D (2008) Qualitative study, - Little consideration of impact of the working context in the 2 case study local authorities. This is potentially	To explore initial assessment practice and the effects of coercive interventions on relationships between social workers and parents	Parents Practitioners	Statutory

highly relevant, given that there may have been idiosyncrasies in assessment practices in the 2 sites			
Robertson (2014) Qualitative study, - Unclear how thematic analysis of semi-structured interviews has been conducted	To understand relational approaches related to child welfare risk assessment	Practitioners	Unclear whether statutory assessment
Selbie J (2009) Qualitative study, +	To seek health visitors' (HVs) opinions on facilitators and enablers in identification and management of risks to children.	Practitioners	Risk assessment by health visitor, including by using CAF
Vincent and Petch (2012) SCR synthesis, +	To review significant case review reports and identify, "lessons that can be learned both locally and nationally and implications for both policy and practice." (p30)	SCR reports relating to children and young people who have died or been seriously harmed	Unclear whether statutory assessment

Narrative summary

A thematic analysis of data from the above 9 studies is presented here. These themes are not grouped according to what 'helps and hinders', as often the same issues could be both a facilitator and a barrier, depending on how they manifested in practice.

Understanding families' social history

Five of the studies (Brandon et al. 2008 +; Devaney et al. 2013 +; Horwath 2005 +; Ofsted 2014 -; Vincent 2012 +) highlighted that effective assessment can be hindered by a failure to ascertain 'social history' and consider what bearing this has on any current needs and risks. This included the social history of the family, but also the individual histories of parents, and their own experiences of being parented (Brandon et al. 2008 +; Devaney et al. 2013 +). One study linked this to inconsistent use of chronologies in assessment (Ofsted 2014 -). Another study (Horwath 2005 +) highlighted this as a particular concern in neglect cases, given that concerns about neglect are often long term and ongoing.

In 2 studies (Devaney et al. 2013 +; Vincent and Petch 2012 +) a tendency not to consider historical information was also linked to assessments 'that were a reactive response to an isolated incident, rather than a holistic exploration of underlying issues' (Vincent and Petch 2012 +, p.71).

Involving children and young people in assessment

Three studies (Horwath 2005 +; Ofsted 2014 -; Vincent and Petch 2012 +) noted that not speaking to, or observing, children hindered effective assessment. One synthesis of serious case review reports noted that some practitioners were unable to see or listen to the child, which meant that they missed clear signs of risk and did not 'explore the reasons why the children had run away or consider that the challenging behaviour they were exhibiting might be due to sexual abuse' (Vincent and Petch 2012 +, p.66).

Involving parents, caregivers and wider family in assessment

Four studies considered the issue of family engagement in assessment (Devaney et al. 2013 +; Platt 2008 -; Robertson 2014 -; Selbie 2009+). The studies note that good family engagement can support the assessment process, and is supported by:

- practitioners listening to and understanding families (Platt 2008 -; Robertson 2014 -; Selbie 2009+)
- practitioners honestly communicating concerns (Robertson 2014 -; Selbie 2009+)
- practitioners being clear about confidentiality, and what information will be shared with whom (Robertson 2014 -).

One study in particular (Platt 2008 -) noted that taking a 'policing' approach to assessment, particularly when assessing under section 47 of the Children Act could have a negative impact on parents, and make them feel 'accused'. One synthesis of serious case review reports (Devaney et al. 2013 +) notes that in the cases reviewed, there was little evidence of engaging wider family in assessment, including fathers.

Focus of assessment

Two studies, both of which had a focus on neglect, commented on the overall focus of assessment. One study noted that, in the cases reviewed, there was a tendency to focus solely on weaknesses in parenting capacity, and not to consider strengths (Horwath 2005 +). This study also found that many assessments focus only on the mother's parenting ability, and do not consider fathers. A second study noted that, in the case files reviewed, many assessments focused on the parents' needs to a greater extent than the child's (Ofsted 2014 -).

Analysis of information gathered

Three serious case review synthesis studies commented on the nature of analysis in assessment (Brandon et al. 2008 +; Devaney et al. 2013 +; Vincent and Petch 2012 +). The studies note that, in the reports reviewed, there was a tendency to record information in a descriptive rather than analytic way. One study (Vincent and Petch 2012 +) commented particularly on the tendency not to adequately analyse the impact of risk factors such as parental drug misuse or domestic abuse, or to re-analyse levels of risk when new events occurred, or new information was available.

Multi-agency information sharing in assessment

Four studies (Brandon et al. 2008 +; Devaney et al. 2012 +; Horwath 2005 +; Vincent and Petch 2012 +) commented on multi-agency information-sharing at the assessment stage. The 3 serious case review syntheses (Brandon et al. 2008 +;

Devaney et al. 2013 +; Vincent and Petch 2012 +) note that a lack of multi-agency information-sharing during assessment was a feature of a number of the reports they reviewed. Horwath (2005 +) also notes that social workers reported frustration in trying to contact busy professionals when gathering information for assessment, meaning that they would get information only from those who were easy to contact. This resulted in assessment decisions being made without information from all relevant professionals.

2. Views of parents and caregivers on aspects of professional practice in relation to assessment

Description of evidence

We found 3 poor quality UK studies which reported having sought the views of parents and caregivers about assessment, as 1 of the sources of evidence considered (Cleaver and Walker 2004 -; Ofsted 2014 -; Platt 2008 -). Two of the studies (Cleaver and Walker 2004 -; Platt 2008 -) reported some of the views of parents in a way that made them distinguishable from the other data sources, albeit minimal data were reported. In the other study, general points were made without it being clear on which data source they were based (see Table 10 for details of the 2 studies).

Narrative summary

Cleaver and Walker (2004 -) report that the majority of parents who were interviewed felt that the referral and assessment process had been positive. They also note that parental satisfaction with the plan resulting from assessment was related to parents and social workers having a shared perspective, families being involved in the plan, families agreeing and committing to plans and plans being realised. Platt (2008 -) reports that parents valued openness and honesty during the assessment process, and did not want to feel that things were being done ‘behind their backs’ (p308).

3. Parent and practitioner views on specific assessment tools

Description of evidence

We found 1 poor quality UK qualitative study which sought parent and practitioner views on a specific assessment tool. The study examined the implementation in a local authority in Scotland of the Graded Care Profile (GCP) (Sen et al. 2014 -). The

same tool was also mentioned in 1 poor quality thematic inspection report (Ofsted 2014 -), although this was not a key focus of this study (see Table 10 for details of this study).

We did not include in this category evaluations of practice within the context of the Assessment Framework in England (Cleaver and Walker 2004 -) or Getting It Right for Every Child in Scotland (Robertson 2014 -) as these were considered to be overarching practice frameworks rather than specific tools. Furthermore, neither of these studies asked for feedback about the frameworks themselves. One study regarding a tool for assessing children thought to have been trafficked (London Safeguarding Children Board 2011 -) is discussed under section 4 below.

The GCP (Srivastava and Polnay 1997) is a standardised framework for assessment of neglect. It breaks care down in to 4 domains comprising physical care, safety, love and esteem. Each item has a 5-point scale with descriptors for each point on the scale. The scale is completed based on observation and parental self-report.

Sen et al. (2014 -) used a mixed methods design to assess parent and practitioner views on the GCP, including: a questionnaire with practitioners who had used the GCP (n=22) and follow-up interviews (n=8); 2 focus groups with practitioners who had used the GCP (n=7); telephone interviews with practitioners who had not used the GCP (n=56); semi-structured interviews with parents who had previously had the GCP used with them (n=4); semi-structured interviews with practitioners who used the GCP with the above parents (n=4); family observation (n=3) followed up by interviews with parents (n=2) and practitioners (n=2).

The study was rated as poor because very little information is given in the paper regarding data collection or analysis methods. When the authors describe their findings, it is not always clear what data source findings are based on. There is little evidence in the paper clearly reporting parents' views on the tool, so the evidence statement below is based on practitioner views only.

Narrative summary

Sen et al. (2014 -) grouped their findings about the GCP under 4 headings: user friendliness, the GCP as an assessment tool, parental engagement with the GCP and 'the final score'. They found the following.

- **User friendliness:** The length of time required to complete the tool, and the complexity of some of the language were perceived to be barriers to its use. Some practitioners alluded to the challenges with the GCP as going beyond the wording but to cultural assumptions underpinning the tool, with 1 professional commenting: 'it has a real middle class feel to it … the language in it and some of the views about good parenting' (p366).
- **The GCP as an assessment tool:** Reportedly positive aspects of the tool were its use in 'breaking down' and structuring assessment of parenting, and highlighting areas where support was needed. However, the tool was seen by some practitioners as 'very very subjective' (p367) and it was noted that some judgements using the tool had to be made using parental self-report rather than observation. In the conclusion for the study, the authors note that 'there is a possibility that attaching a numerical grade to care within the GCP gives a misleading veneer of objectivity to what is a professional judgement call' (p371).
- **Parental engagement with the GCP:** The study reports that 2 of the 7 involved families had had positive experiences of using the GCP, suggesting that experiences were less positive in the remaining 5 cases. The authors note that tensions could arise when professionals thought that elements of parenting were 'worse than parents themselves did' (p369). Reporting of data from parents themselves is minimal.
- **'Final score':** The GCP was seen to not be the root of disagreements between parent and social workers, but it did crystallise underlying issues where professionals and parents disagreed about quality of care.

4. Assessment in cases of child trafficking

Description of evidence

We found 2 studies which looked specifically at practice in relation to assessment of children who were suspected or confirmed to have been trafficked. These also considered practice in relation to age assessment; this has not been included as it does not relate to assessment of risk or need.

One was a poor quality UK mixed methods study (London Safeguarding Children Board 2011 -), which examined practitioner perceptions of the London Safeguarding Children Board (SCB) Trafficked Children Toolkit via 3 surveys of local authorities, a

survey of police forces, a national monitoring workshop for 10 pilot authorities and a multi-agency professionals' workshop. The study was rated as poor quality due to the very poor information regarding methodology, including how pilot sites were recruited, which individuals participated within those sites and how results were analysed.

The second was a poor quality UK qualitative study, conducted in Glasgow (Rigby 2011 -), which aimed to identify factors that facilitate or hinder intervention in relation to trafficked children. The research report includes a specific section on assessment. The research involved a review of the case files of 75 unaccompanied asylum-seeking children, 7 interviews with professionals and 2 focus groups involving 9 professionals. The study was rated as poor quality because it was not clear which data were gathered via interview, and which via focus group. There is also relatively little presentation of primary data in the study report.

Narrative summary

The study looking at the use of the London SCB Trafficked Children Toolkit (London SCB 2011 -) found that:

- practitioners reported that some of the materials in the toolkit were perceived to be useful, with the Risk Assessment Matrix receiving the most support
- the Assessment Framework for trafficked children was also perceived to be useful, but was also seen as lengthy and repetitive; participants thought the assessment duplicated aspects of existing assessment processes, and risked children being seen as 'separate' from mainstream child protection processes
- practitioners also thought that multiple assessment processes could have a potentially harmful impact on children.

Rigby et al. (2011 -) found that case file analysis showed that initial identification and child protection assessments were 'largely absent' (p333). Practitioners also reported that, given that young people often did not disclose being trafficked, they were reliant on 'indirect indicators', but were unsure how these should be incorporated in to the assessment process. Practitioners also reported challenges in working with children from a wide range of differing cultural experiences, many of

whom were continuing to experience trauma and fear. One respondent said ‘How do you work with a young person from 1 of 23 countries that we work with? − people can’t tell you’ (p329). Practitioners reported that, in some cases, young people continued to be ‘groomed’ by their traffickers, which gave rise to further challenges in identification and assessment. The distinction between ‘trafficking’ and ‘smuggling’ (those who are forced versus those who are consenting) was found to be problematic and confusing for workers.

Economics

No economic analysis or modelling was undertaken for this review question.

Evidence statements

ES126	**ES126. Understanding families’ social history in assessment** There is a moderate amount of mixed quality evidence from 5 UK studies: 3 moderate quality serious case review syntheses (Brandon et al. 2008 +; Devaney et al. 2013 +; Vincent 2012 +), 1 moderate quality qualitative study (Horwath 2005 +) and 1 poor quality thematic inspection study (Ofsted 2014 -) that assessment of risk and need in relation to child abuse and neglect can be hindered by insufficient consideration of family ‘social history’.
ES127	**ES127. Involving children and young people in assessment** There is some mixed quality evidence from 3 UK studies: 1 moderate quality serious care review synthesis (Vincent and Petch 2012 +), 1 moderate quality qualitative study (Horwath 2005 +) and 1 poor quality thematic inspection study (Ofsted 2014 -) that assessment of risk and need in relation to child abuse and neglect can be hindered by not directly speaking to and observing children and young people.
ES128	**ES128. Involving parents, caregivers and families in assessment** There is some evidence of mixed quality from 4 UK studies: 1 moderate quality serious care review synthesis (Devaney et al. 2013 +), 1 moderate quality qualitative study (Selbie 2009 +) and 2 poor quality qualitative studies (Platt 2008 -; Robertson 2014 -) that good engagement of the whole family facilitates the assessment process, and is supported by practitioners listening to and understanding families (Platt 2008 -; Robertson 2014 -; Selbie 2009+), with practitioners honestly communicating concerns (Robertson 2014 -; Selbie 2009 +) and practitioners being clear about confidentiality and what information will be shared with whom (Robertson 2014 -).
ES129	**ES129. Focus of assessment in child neglect** There is a small amount of evidence of mixed quality from 2 UK studies: 1 moderate quality qualitative study (Horwath 2005 +) and 1 poor quality thematic inspection (Ofsted 2014 -) that assessments of risk and need in relation to child neglect tend to focus to a greater extent on parental weaknesses rather than strengths (Horwath 2005 +) and focus more on mothers than fathers (Ofsted 2014 -).

ES130	**ES130. Analysing information in assessments** There is some evidence from 3 moderate quality UK serious case review syntheses (Brandon et al. 2008 +; Devaney et al. 2013 +; Vincent and Petch 2012 +) that effective assessment is hindered by a lack of analysis, including of the impact of risk factors such as parental drug misuse or domestic abuse.
ES131	**ES131. Multi-agency information sharing in assessment** There is some evidence from 4 moderate quality UK studies: 3 serious care review syntheses (Brandon et al. 2008 +; Devaney et al. 2013 +; Vincent and Petch 2012+) and 1 moderate quality qualitative study (Horwath 2005 +) that effective assessment is hindered by a lack of information sharing between agencies.
ES132	**ES132. Parent and caregiver views on assessment** There is a small amount of evidence from 2 poor quality qualitative UK studies (Cleaver and Walker 2004 -; Platt 2008 -) that parents value assessment processes in which: they are actively involved; professionals are open and honest; there is a shared perspective; and the assessment leads to plans which are acted upon.
ES133	**ES133. Practitioner views of the Graded Care Profile assessment tool** There is evidence from 1 poor quality qualitative UK study (Sen et al. 2014 -) and 1 poor quality thematic inspection study (Ofsted 2014 -) that practitioners found the Graded Care Profile helpful in breaking down and structuring assessment of neglect. However Sen et al. (2014 -) also found that the length of time of time required to complete the tool, the complexity and cultural assumptions of the language, and the tension between subjectivity of judgement compared to the seeming objectivity of a final 'score' were perceived to be unhelpful.
ES134	**ES134. Practitioner views on London Safeguarding Children Board Trafficked Children Toolkit** There is evidence from 1 poor quality UK mixed methods study (London SCB, 2011 -) that practitioners find some elements of the London SCB Trafficked Children Toolkit useful, in particular the risk assessment matrix and assessment framework. However, practitioners thought the assessment could duplicate aspects of existing assessment processes, and risked children being seen as 'separate' from mainstream child protection processes.
ES135	**ES135. Aspects of professional practice – assessment of children of who have been trafficked** There is evidence from 1 poor quality UK qualitative study (Rigby et al. 2011 -) that practitioners assessing children who are known or suspected to have been trafficked are hindered by the following factors: a lack of clarity about how to include 'indirect indicators' of trafficking in their assessment; lack of knowledge of the wide variety of cultures from which children have come; knowledge of how to work with children who are traumatised; dealing with ongoing grooming issues; the distinction between trafficking and smuggling.

Included studies for these review questions

Brandon M, Belderson P, Warren C et al. (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005. London: Department of Education

Cleaver H and Walker S (2004) From policy to practice: the implementation of a new framework for social work assessments of children and families. Child & Family Social Work 9: 81-90

Devaney J, Bunting L, Hayes D et al. (2013) Translating learning into action: an overview of learning arising from case management reviews in Northern Ireland 2003-2008. Belfast: Queen's University Belfast

Horwath J (2005) Identifying and assessing cases of child neglect: learning from the Irish experience. Child and Family Social Work 10: 99-110

London Safeguarding Children Board (2011) Final monitoring report: local authority pilots of the London safeguarding trafficked children guidance and toolkit. London: London Safeguarding Children Board

Ofsted (2014) In the child's time: professional responses to neglect. Manchester: Ofsted

Platt D (2008) Care or control? The effects of investigations and initial assessments on the social worker-parent relationship. Journal of Social Work Practice 22: 301-15

Rigby P (2011) Separated and trafficked children: the challenges for child protection professionals. Child Abuse Review 20: 324-40

Robertson A (2014) Child welfare assessment practices in Scotland: an ecological process grounded in relationship-building. Journal of Public Child Welfare 8: 164-89

Selbie J (2009) Health visitors' child protection work: exploratory study of risk assessment. Community practitioner: the journal of the Community Practitioners' and Health Visitors' Association 82(5): 28-31

Sen R, Green Lister P, Rigby P et al. (2014) Grading the Graded Care Profile. Child Abuse Review 23: 361-73

Vincent S and Petch A (2012) Audit and Analysis of Significant Case Reviews. Edinburgh: The Scottish Government

3.6 Early help – effective interventions for children, young people, parents and carers at risk of abuse and neglect

Introduction to the review question

The purpose of this review, comprising 5 questions, was to assess the effectiveness of interventions aiming to provide early help for children and young people identified as at risk of child abuse and neglect, and their caregivers and families. For this question, we also reviewed views and experiences evidence alongside effectiveness evidence. In later questions, this type of evidence was reviewed under 'aspects of professional practice'.

We used the definition of early help in 'Working Together to Safeguard Children' (2013) that support is provided 'as soon as a problem emerges'. In the context of abuse and neglect, this means when 'showing early signs of abuse and/or neglect'. This question therefore considered interventions provided to children and young people and/or their caregivers and families following identification of risk or need which is higher than in the general population, but not sufficiently high to meet the threshold for statutory services.

We devised 5 questions, aiming to assess the effectiveness of early help interventions for a range of forms of abuse. The question in relation to child trafficking (question 13) was focused on early help for children at risk of trafficking within the UK. This was on the basis that children at risk in other countries are outside the scope of this guideline. However, we found no eligible studies in relation to early help for child sexual abuse (question 10), female genital mutilation (question 11), forced marriage (question 12) or child trafficking (question 13). Due to the gaps in evidence, expert witnesses were invited to speak on each of these topics.

The evidence reviewed for this question comprised randomised controlled trials (RCTs) and systematic reviews of RCTs. The majority of included studies were awarded a moderate (+) quality rating, based on a combination of external and

internal validity ratings. Part of the reason that no study was awarded ++ is because the majority were conducted outside the UK (primarily the USA and Australia), and so caution needs to be exercised when applying their findings to a UK context.

Early help home visiting interventions were prioritised for economic analysis, and a piece of economic modelling work was undertaken as part of the review work for these questions.

Review questions

9. What is the impact of interventions aiming to provide early help to children and young people identified as at risk of child abuse and neglect?

10. What is the impact of interventions aiming to provide early help to children and young people identified as at risk of child sexual abuse? (Prevention of occurrence)

11. What is the impact of interventions aiming to provide early help to children and young people identified as at risk of female genital mutilation? (Prevention of occurrence)

12. What is the impact of interventions aiming to provide early help to children and young people identified as at risk of forced marriage? (Prevention of occurrence)

13. What is the impact of interventions aiming to provide early help to children and young people identified as at risk of internal child trafficking? (Prevention of occurrence).

We also included relevant evidence from:

1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

Summary of the review protocol

The protocol sought to identify studies of the effectiveness of interventions aiming to provide early help for children and young people identified as at risk of child abuse and neglect, and their caregivers and families, examining which interventions are effective, and which are ineffective, identify whether there are any harmful interventions, and assess the cost effectiveness of interventions.

The study designs originally included for these questions were randomised or quasi-RCTs; impact evaluation (for example, prospective comparative evaluation); economic evaluation; case control studies and systematic reviews of these studies.

Full protocols can be found in Appendix A.

Population

Children and young people (under 18) who are at risk of abuse or neglect and/or their caregivers and families.

Intervention

Interventions aiming to provide early help in relation to abuse and neglect for children and young people and their caregivers and families. Early help is defined in 'Working Together to Safeguard Children' (2013) as support provided 'as soon as a problem emerges'. In the context of abuse and neglect, this means when 'showing early signs of abuse and/or neglect'. This review question will therefore consider interventions provided to children and young people and/or their caregivers and families following identification of risk or need which is higher than in the general population, but not sufficiently high to meet the threshold for statutory services.

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children's own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings

- schools and colleges
- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Primary outcome: Incidence of abuse and neglect. (We stipulated that all included studies must measure this outcome.)

Secondary outcomes: Acceptability to children, young people and their caregivers and families (including as reported by adult survivors of child abuse and neglect); quality of parenting and parent-child relationships, including quality of attachment; children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM)); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials registries, were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and October 2014. Update searching of the bibliographic databases searches took place in April 2016.

Summary from re-run searches

An updated search was carried out in April 2016 to identify any new studies relating to the effectiveness questions (5, 7, 9-13, 15-19) published since the original searches were conducted for this guideline. This search used the same search terms and databases as the main search.

As we originally conducted a single search for all of the original 21 questions, the search identified a large number (10,833) items which we used as a 'database' within which to search for studies relevant to our questions. This included specific searches for interventions for which evidence had already been reviewed.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs. Outputs were initially screened against an exclusion tool informed by the overall parameters of the scope.

Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific criteria for those questions. For questions 9-13 these were as follows:

- country (study is not from Europe, Israel, Australia, Canada, USA, New Zealand)
- evidence (randomised or quasi-RCTs; impact evaluation (for example, prospective comparative evaluation); economic evaluation; case control studies and systematic reviews of these studies
- population (not children and young people (under 18) who are at risk of abuse or neglect and/or their caregivers and families)
- intervention (not an intervention aiming to provide early help in relation to abuse and neglect for children and young people and their caregivers and families)
- outcome (does not measure primary outcome).

For questions 1 and 2 these were as follows:

- country (study is not from the UK)
- evidence (not an empirical study including qualitative studies, qualitative components of effectiveness and mixed methods studies, survey studies or systematic reviews of these study types)
- population (population is not children and young people who are at risk of, are experiencing, or have experienced abuse or neglect; their caregivers and families; adult survivors of abuse or neglect; practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families)
- topic (study does not relate to the process of recognising abuse and/or neglect, the process of assessment, services providing early help, services providing intervention following abuse or neglect).

We identified 119 potentially relevant studies for question 9 based on title and abstract. Due to the high number of studies we decided to focus on the highest quality study designs only, randomised and quasi-RCTs and systematic reviews of these. This resulted in 79 studies being screened on full text. Following full text screening 19 studies were included, 2 of which were reviewed from both an

effectiveness and cost-effectiveness perspective, and 1 of which was reviewed from a cost-effectiveness perspective only.

After an update search of literature from 1 January 2014 to 30 April 2016 we identified a further 63 papers of possible relevance to this question. Following full text review using the same criteria as the previous screening process, 7 additional studies were included, 2 of which were reviewed from a cost-effectiveness perspective only.

See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence

1. Home visiting

Description of the evidence

Evidence of the effectiveness of home visiting programmes was provided in 1 moderate quality systematic review of reviews (Barlow et al. 2006 +), 2 moderate quality systematic reviews (Nelson et al. 2013 +; Peacock et al. 2013 +), 1 moderate quality UK trial (Robling et al. 2015 +), 1 moderate quality Dutch trial (Mejdoubi et al. 2015 +) 6 moderate quality US RCTs (Dishion et al. 2015 +; DuMont et al. 2011 +; Guterman et al. 2013 +; LeCroy and Krysik 2011 +; Silovsky et al. 2011 +; Zielinski et al. 2009 +) and 1 poor quality US RCT (Green et al. 2014 -).

Only evidence relating to programmes targeted at children at risk of abuse and neglect and their caregivers was considered. For home visiting interventions, this was typically ascertained using a screening process assessing risk factors such as young age (typically <19), single parent, delayed prenatal care, poor engagement with prenatal care services, single parent, depression, low educational level, drug abuse, troubled family relations (for example, DuMont et al. 2011 +; Green et al. 2014 -), parental substance misuse, mental health issues or intimate partner violence (for example, Silovsky et al. 2011 +). Clearly, participants meeting these criteria are likely to represent a range of severity of underlying risk, meaning that the populations of the studies are likely to have been heterogeneous.

Views and experience evidence relating to home visiting was provided in 5 qualitative studies of moderate quality (Allen 2007 +; Domian et al. 2010 +; Krysik et al. 2008 +; Paris 2008 +; Stevens et al. 2005 +). These were all American studies which provided evidence on 5 different models of home visiting (Every Child Succeeds, Help Me Grow, My Baby and Me, Healthy Families America – Arizona, and Visiting Moms. Four studies asked parents for their views on the programme, while 2 included home visitors (1 also included home visitation supervisors).

Description of the intervention

The core components of home visiting interventions reported in the papers identified were as follows:

- regular visits which may initially be of a high intensity (that is, weekly visits until the child is 6 months old) and then decrease over time (for example, UK Family Nurse Partnership reported in Robling et al. (2015 +), Healthy Families America, reported in DuMont et al. 2011 +; Green et al. 2014 -)
- the programme often begins in the antenatal period (for example, Barlow et al. 2006 +)
- visitors mostly aim to provide advice and support on child development (for example, Family Nurse Partnership, reported in Zielinski et al. 2009 +), child safety, and parenting skills and discipline strategies (for example, DuMont et al. 2011 +; Silovsky et al. 2011 +), access to health and social services (for example, Robling et al. 2015 +)
- visitors also often attempt to provide a source of emotional support for parents and encourage them to enhance their social support networks, as well as helping parents to access other services such as child health care services or domestic violence, or substance abuse services (for example, Guterman et al. 2013 +; LeCroy and Krysik 2011 +).

However, the interventions were also heterogenous in terms of:

- one intervention (Family Check-Up) comprised only 1 annual session, rather than regular sessions (Dishion et al. 2015 -)
- the qualification of the home visitor – ranging from a paraprofessional with 12 hours of on-the-job training, followed by monthly training and regular supervision

thereafter (DuMont et al. 2011 +; Guterman et al. 2013 +) to public health nurses (Robling et al. 2015 +; Zielinski et al. 2009 +) and degree-qualified individuals (for example, Robling et al. 2015 +; LeCroy and Krysik 2011 +)

- the duration of the interventions varied from 1 year to up to 5 years (Healthy Families Alaska trial, reported in Nelson et al. 2013 +).

Although most home visiting interventions aimed to effect change through the provision of wide-ranging advice and support, the Safecare model also included a structured training component which directly addressed parenting skills.

Theoretical underpinnings for each of the interventions were not given, but a common theme was a reference to ecological models of family functioning (for example, Guterman et al. 2013 +; Robling et al. 2015 +; Silovsky et al. 2011 +), self-efficacy (for example, Mejdoubi et al. 2015 +; Robling et al. 2015 +) and attachment (for example, Robling et al. 2015 +).

Comparison interventions often included information on other services and how to access them or information on the child's developmental screening assessment (for example, DuMont et al. 2011 +; Green et al. 2014 -; LeCroy and Krysik 2011 +). The comparison condition for each study is shown in Table 11.

Table 11. Studies relating to home visiting and outcomes measured

Study	Quality	Sample size	Population	Intervention	Comparison group	Incidence of abuse and neglect	Risk of abuse and neglect	Quality of parenting	Child health and wellbeing	Caregiver/parent health and wellbeing	Satisfaction with services
Reviews reported in Barlow et al. 2006 +											
Bilukha et al. (2005)	Rated by authors as 8/9	22 studies	High-risk groups of parents and children	Home visitation	Not reported	Abuse and neglect Out of home placement	-	-	-	-	-
Elkan et al. (2000)	Rated by authors as 6/9	34 studies	Parents at risk of abuse/poor parenting	Home visiting programmes	Not reported		Parenting skills				
Geeraert et al. (2004)	Rated by authors as 5/9	40 studies	Families of young children identified as at risk for abuse and neglect	Home visiting	Not reported		Child functioning Parent–child interaction Parent functioning Family functioning				
Studies reported in Nelson et al. 2013 +											
Barlow et al. 2007 (UK)	Rated by authors as fair	121	Risk factors including poverty, mental illness, and domestic violence	Family Partnership model	Not reported	CPS reports Removal of child from home	-	-	Admissions to hospital	-	-
Bugental et al. (2009) (USA)	Rated by authors as fair	110	Parents of children born at	Cognitive interventions	Not reported	Self-reported child abuse and neglect	-	-		-	-

			medical risk								
Duggan et al. (2007) (USA)	Rated by authors as fair	364	At risk families	Healthy Families Alaska	Not reported	CPS reports Self-reported child abuse and neglect	-	-	Emergency department visits Admissions to hospital	-	-
Duggan et al. (2004) (USA)	Rated by authors as fair	643	At risk families	Hawaii Healthy Start	Not reported	CPS reports Foster placement Self report	-	-	Admissions to hospital	-	-
DuMont et al. (2008) (USA)	Rated by authors as fair	1173	At risk families	Healthy Families New York	Not reported	CPS reports Self report	-	-		-	-
El-Mohandes et al. (2003) (USA)		286	At risk mothers	Reported as 'NA'	Not reported	-	-	-	Adherence to immunisations	-	-
Fergusson et al. (2005) (New Zealand)	Rated by authors as fair	433	At risk families	Community screening	Not reported	CPS reports Self report	-	-	Emergency department visits Admissions to hospital	-	-
Koniak Griffin et al. (2003) (USA)	Rated by authors as fair	101	At risk families	Community health services	Not reported			-	Emergency department visits Admissions to hospital		-
Lowell et al. (2011) (USA)	Rated by authors as fair	157	At risk families	Child First primary care clinics	Not reported	CPS reports	-	-	-	-	-
Studies reported in Peacock et al. 2013 +											
Barth (1991)	Rated by authors	191	At risk women	Child Parent	Not reported	Abuse and neglect	-	-	-	-	-

	as 13-14/15			Enrichment Project							
Black et al. (1995)	Rated by authors as 15/15	130	Children with non-organic failure to thrive	Home visiting – model not reported	Not reported	-	-	-	Psychomotor and cognitive development	-	-
Caldera et al. (2007)	Rated by authors as 13-14/15	325	Reported as 'families'	Healthy Families Alaska	Not reported	-	-	-	Psychomotor and cognitive development Child behaviour	-	-
Cupples et al. (2011) (Ireland)	Rated by authors as 13-14/15	343	First time mothers	Home visiting – model not reported	Not reported	-	-	-	Psychomotor and cognitive development	-	-
Bugental et al. (2002) (USA)	Rated by authors as 13-14/15	96	Mothers at moderate risk	Home visitation	Not reported	Harsh parenting Physical abuse	-	-	-	-	-
Duggan et al. (2009) (USA)	Rated by authors as 13-14/15	325	At risk families	Healthy Families Alaska	Not reported	Substantiated child maltreatment	-	-	-	-	-
Duggan et al. (2004a, b) (USA)	Rated by authors as 13-14/15	643	At risk families	Healthy Start Program	Not reported	Not reported	-	-	-	-	-
Du Mont et al. (2008) (USA)	Rated by authors as 13-14/15	1297	At risk families	Healthy Families New York	Not reported	Physical aggression and harsh parenting	-	-	-	-	-
Johnson et al. (1993) (Ireland)	Rated by authors	262	First time mothers	Community Mothers'	Not reported	-	-	-	Hospitalisation	-	-

	as 13-14/15			Programme							
Kartin et al. (2002) (USA)	Rated by authors as 15/15	78	Substance abusing mothers	Seattle Birth 3 Program	Not reported	-	-	-	Psychomotor and cognitive development	-	-
Nair et al. (2003) (USA)	Rated by authors as 13-14/15	161	Substance abusing mothers	Home visiting – model not reported	Not reported	-	-	-	Psychomotor and cognitive development	-	-
Other studies											
Dishion et al. (2015) (USA)	Moderate	731	Families with low income and risk for future child behaviour problems	Family Check-Up	Services as usual	Incidence of neglect	-	Dyadic parent engagement	-	-	-
Du Mont et al. (2011) (USA)	Moderate	1173	Mothers at risk for child abuse and neglect	Healthy Families New York	Information only	Reports of maltreatment Self report	-	-	Risk of juvenile delinquency	-	-
Green et al. (2014) (USA)	Moderate	2264, interviewed 808	First time parents at risk	Healthy Families Oregon	Information only	-	Parenting stress	Self-report Parent-child interaction Family functioning	Child development	Depressive symptomatology	-
Guterman et al. (2013) (USA)	Moderate	138	Families (primarily mothers) deemed to be at high risk	Home-based parent aide services	Case management only	Self-report Observation	Parenting stress Maternal depression, anxiety, hostility	-	-	-	-

							and drug use				
LeCroy and Krysik (2011) (USA)	Moderate	195	Families at risk of abuse and neglect	Healthy Families Arizona	Information only	Disciplinary practices	-	Parenting attitudes and practices	-	Parenting support Mental health and coping	-
Mejdoubi et al. (2015) (Netherlands)	Moderate	460	Pregnant women under 26, low educational level, first time pregnancy	VoorZorg (Dutch adaptation of Family Nurse Partnership)	Usual care	Child protective services reports	-	Quality of home environment	Internalising and externalising behaviour	-	-
Robling et al. (2015) (UK)	Moderate	1645	First time mothers under age 19	Family Nurse Partnership	Usual care	Safeguarding (measured via primary care) Referrals to children's social care Intimate partner violence	Parental role strain	Maternal-child interaction	Attendance and admission to emergency department/hospital for injuries and ingestions; Child safety; Cognitive and language development.	Psychological distress Depressive symptoms General self-efficacy Unplanned hospital admissions	-
Silovsky (2011)	Moderate	105	Caregivers with substance misuse, mental health issues or intimate partner violence	SafeCare	Standard home-based mental health services	Child welfare referrals Removal data	Child abuse potential Conflict tactics scale Beck depression inventory Family resources	-	-	-	Satisfaction Cultural competence

Zielinski (2009)	Moderate	237	First time low income mothers	Family Nurse Partnership	Screening and visits by public health nurse	CPS reports	-	-	-	-	-

Narrative summary

Impact on incidence of abuse and neglect

One review of reviews (Barlow et al. 2006 +) included 1 systematic review which examined impact on incidence of abuse and neglect[6] (Bilukha et al. 2005, cited in Barlow et al. 2006 +). This review found an impact of home visiting interventions on incidence of abuse and neglect, but only if surveillance bias was controlled for.

The results from the remaining systematic reviews and RCTs are reported here according to different measures of incidence, namely:

- referrals to children's social care/child protective services
- legal removal of the child
- parentally self-reported abuse and neglect
- observed abusive or neglectful behaviours.

Due to the complexity of data for this aspect of the review, study findings have been summarised in Table 12.

[6] A second review (Macmillan et al. 1994) also looked at incidence of abuse and neglect, but included universal as well as targeted programmes and so was excluded.

Table 12. Findings of studies of home visiting in relation to incidence of abuse and neglect

Study[7]	Quality	n	CPS reports	Removal	Self-reported child abuse and neglect	Observed harsh parenting or neglect or indicator unclear
Reviews reported in Barlow et al. 2006 +						
Bilukha et al. (2005)	Rated by authors as 8/9	22 studies	-	-	-	Impact when surveillance bias controlled for, no effect sizes reported
Studies reported in Nelson et al. 2013 +						
Barlow et al. (2007) (UK)	Rated by authors as fair	121	NS	NS, no effect sizes reported	-	- -
Bugental et al. (2009) (USA)	Rated by authors as fair	110	-	-	NS	- -
Duggan et al. (2007) (USA)	Rated by authors as fair	364	NS	-	NS	- -
Duggan et al. (2004) (USA)	Rated by authors as fair	643	NS	NS, no effect sizes reported	NS	- -
DuMont et al. (2008) (US)	Rated by authors as fair	1173	NS	-	Year 1 serious abuse p=0.04, no effect sizes reported Year 2 serious physical abuse p=0.03 no effect sizes reported	- -

[7] Note – some studies are reported in multiple published and unpublished papers.

Fergusson et al. (2005) (New Zealand)	Rated by authors as fair	433	NS	-	Fewer parents reporting severe physical punishment p<0.01, OR=0.35 (95% CI 0.15 to 0.80)	- -
Lowell et al. (2011) (USA)	Rated by authors as fair	157	Significant in favour of intervention OR 2.1 (95% CI 1.1 to 4.4)	-	-	- -
Studies reported in Peacock et al. 2013 +						
Barth (1991)	Rated by authors as 13-14/15	191	-	-	-	NS, no effect sizes reported
Bugental et al. (2002)	Rated by authors as 13-14/15	96	-			Enhanced group had less harsh parenting and physical abuse (no effect sizes reported)
Duggan et al. (2009)	Rated by authors as 13-14/15	325	Use data from Nelson et al. systematic review			
Duggan et al. (2004a, b)	Rated by authors as 13-14/15	643	Use data from Nelson et al. systematic review			
Du Mont et al. (2008)	Rated by authors as 13-14/15	1297	Use data from Nelson et al. systematic review			
Other studies						
Dishion et al. (2015) (USA)	Moderate	731	-	-	-	The analysis found no direct effect of FCU upon neglect variables at age 4 follow-up, although significant relationship between FCU and positive engagement, and between

						positive engagement and neglect variables
Du Mont et al. (2011) (USA)	Moderate	1173	NS, Adjusted Odds Ratio (AOR) 1.13	NS, AOR 0.87	NS in relation to overall presence of abuse Significant difference in favour of intervention on frequency of serious physical abuse with small effect size ES=-0.20	
Guterman et al. (2013) (USA)	Moderate	138			NS for psychological aggression and physical assault	Intervention group poorer household adequacy scores, (d=-0.58)
LeCroy and Krysik (2011) (US)	Moderate	195			Marginally significant impact on disciplinary practices, d=0.25	
Mejdoubi (2015) (Netherlands)	Moderate	460	Intervention group were significantly less likely to have had a child protective services Report (RR=0.58, 95% CI 0.28 to 0.96)	-	-	-
Robling (2015) (UK)	Moderate	1645	Intervention group significantly more likely to have safeguarding event noted in GP records AOR 1.85, (CI 95% 1.02 to 2.85) p=0.005. Lifetime referrals to social services NS	-	Intimate partner violence NS	-

Silovsky (2011) (USA)	Moderate	105	NS except for reports due to domestic violence ($p<0.01$, no effect size reported or calculable)	NS, no effect sizes reported	-	-
Zielinski (2009) (USA)	Moderate	237	All forms of abuse: NS Neglect: Marginally significant in favour of intervention group ($p=0.07$, no effect sizes reported or calculable)	-	-	-

1. Referrals to children's social care/child protective services

In 1 of the systematic reviews (Nelson et al. 2013 +) incidence of child protective services (CPS) involvement was measured in 6 studies. Five showed no significant difference between intervention and control groups (Barlow et al. 2007; Duggan et al. 2004, 2007; DuMont et al. 2008; Fergusson et al. 2005). One study found that the intervention group had significantly less CPS involvement 3 years after enrolment than the comparison group (Lowell et al. 2011, cited in Nelson et al. 2013 +; OR 2.1, 95% CI 1.1-4.4.)

One moderate quality UK study (Robling et al. 2015 +), 1 moderate quality Dutch study (Mejdoubi et al. 2015 +) and 3 moderate quality US RCTs (DuMont et al. 2011 +; Silovsky et al. 2011 +; Zielinski et al. 2009 +) measured the impact of home visiting on abuse and neglect, as measured by referrals to CPS. The UK study (Robling et al. 2015 +) found that rates of recording in GP notes indicating the initiation, progression or closure of safeguarding processes were significantly higher among those in the Family Nurse Partnership group (AOR 1.85, CI 95% 1.02 to 2.85). However, it should be noted that health records rather than data from children's social care were used, and that there was a high level of missing data in both the intervention and control groups for this outcome.

One study (Mejdoubi et al. 2015 +) found that those in the intervention group were significantly less likely to have had a child protective services report (RR=0.58, 95% CI 0.28 to 0.96). The 3 US studies found no significant differences between intervention and control (DuMont et al. 2011 +; Silovsky et al. 2011 +; Zielinski et al. 2009 +).

2. Legal removal of child from the home

Legal removal of the child from the home was measured in 2 studies reported in the Nelson et al. (2013 +) review (Barlow et al. 2007; Duggan et al. 2004). Both showed no significant difference on this measure between intervention and control. Two moderate quality US RCTs also measured rates of removal from the home (DuMont

et al. 2011 +; Silvosky et al. 2011 +). These also showed no significant difference between the intervention and control group.

3. Parentally self-reported abuse and neglect

Self-reported abuse and neglect was measured in 5 studies reported in the Nelson et al. (2013 +) review (Bugental et al. 2009; Duggan et al. 2004, 2007; DuMont et al. 2008; Fergusson et al. 2005). One study found that parents in the intervention group reported significantly less severe physical punishment (Fergusson et al. 2005, OR 0.35, 95% CI 0.15 to 0.80), and another that there was significantly less self-reported abuse at 24 months (DuMont et al. 2008, p=0.03). Two studies showed no significant difference (Duggan et al. 2004, 2007, no effect sizes reported). One study showed very low rates of self-reported abuse in both intervention and control (Bugental et al. 2009). It is unclear whether these were significantly different from each other.

Three moderate quality US RCTs (DuMont et al. 2011 +; Guterman et al. 2013 +; LeCroy and Krysik 2011 +) and 1 moderate quality UK RCT (Robling et al. 2015 +) examined parentally self-reported abuse and neglect, including self-reported intimate partner violence (Robling et al. 2015 +). Two studies found no difference between intervention and control (Guterman et al. 2013 +; Robling et al. 2015 +). One study (DuMont et al. 2011 +) found impact on some parental self-report measures (non-violent discipline and frequency of serious physical abuse), but the effect sizes were small (ES: 0.14 and
-0.20 respectively). Moreover, no impact was found on other self-report measures (psychological aggression, serious physical abuse and neglect). One study found a marginally statistically significant (p=0.10) impact on disciplinary practices at year 1, with small effect size (d=0.26)[8] (LeCroy and Krysik 2011 +).

4. Observed abusive/neglectful behaviours

One systematic review (Peacock et al. 2013 +) reported 2 studies (Barth et al. 1991; Bugental et al. 2002, cited in Peacock et al. 2013 +) which measured harsh parenting. One study found no effect of the home visiting intervention on harsh parenting (Barth et al. 1991, cited in Peacock et al. 2013 +, no effect sizes reported)

[8] Calculated by reviewing team.

and 1 found that the 'enhanced' group had less harsh parenting and physical abuse (no effect sizes reported) (Bugental et al. 2002, cited in Peacock et al. 2013 +).

One moderate quality US RCT (Guterman et al. 2013 +) found the intervention group were significantly poorer in terms of an observational measure of household adequacy, with medium effect size (d= -0.58)[9]. One moderate quality US randomised study (Dishion et al. 2015 +) found no direct relationship between membership of the intervention group and observed neglect, but did find a significant relationship when mediated by the impact of the intervention on positive engagement between parent and child (no effect sizes reported or calculable).

5. Subgroup analysis

There was a small amount of evidence that home visiting provided at the early help stage has greater impact on incidence of abuse and neglect for families with higher levels of risk. In 2 moderate quality trials – a US RCT reported in 2 papers (DuMont et al. 2008, reported in Peacock et al. 2013 +[10] and its 7-year follow-up study, DuMont et al. 2011 +) and a second US RCT (Zielinski et al. 2009 +) found there was no significant impact on incidence of abuse and neglect in the sample as a whole, but significant impact was observed in 3 higher risk subgroups:

- mothers who were both 'poor and unmarried' at baseline (Zielinski et al. 2009 +)
- first-time mothers less than 19 years old (DuMont et al. 2008 +, cited in Peacock et al. 2013 +)
- women with a higher prior rate of substantiated CPS reports than the sample as a whole (DuMont et al. 2008 +, cited in Peacock et al. 2013 +, DuMont et al. 2011 +).

There was a small amount of evidence that home visiting provided at the early help stage has a greater impact on incidence of neglect. In 1 moderate quality US RCT (Zielinski et al. 2009 +), overall rates of CPS reports for neglect differed significantly

[9] Calculated by reviewing team.
[10] This study is also reported in Barlow et al. (2006 +). This study is only counted once in reporting for each evidence statement.

between the treatment and comparison groups, whereas they did not for maltreatment in general.

Impact on risk of abuse and neglect

There was some evidence that home visiting interventions provided at the early help stage decrease parental risk of abuse and neglect. Two of the included reviews considered in 1 moderate quality systematic review of reviews (Barlow et al. 2006 +) found evidence for impact on various outcomes associated with abuse and neglect including parenting skills (Elkan et al. 2000, reported in Barlow et al. 2006 +, no effect sizes reported), parental risk reduction (ES=0.33) and family functioning (ES=0.33) (Geeraert et al. 2004 reported in Barlow et al. 2006 +).

Two moderate quality US RCTs (Guterman et al. 2013 +; Silovsky et al. 2011 +) and 1 poor quality US randomised controlled trial (Green et al. 2014 -) measured the impact of home visiting interventions on a range of measures of risk of abuse and neglect, including parenting stress. Two studies (Guterman et al. 2013 +; Silovsky et al. 2011 +) found no difference between intervention and control on a range of measures. One study (Green et al. 2014 -) found a marginally significant (p=0.057) impact of home visiting on parenting stress (effect size not reported).

Impact on quality of parenting and parent-child relationships

One moderate quality UK RCT (Robling et al. 2015 +), 1 moderate quality Dutch RCT (Mejdoubi et al. 2015 +), 2 moderate quality US RCTs (Dishion et al. 2015 +; LeCroy and Krysik 2011 +) and 1 poor quality US RCT (Green et al. 2014 -) examined the impact of home visiting on parenting and parent-child relationships. One study (Mejdoubi et al. 2015 +) found there was no significant difference in parenting as measured by IT-HOME scores. One study (Robling et al. 2015 +) found no difference in maternal-child interaction outcomes, although the intervention group did show a marginally significantly (p=0.11) lower ‘parental role strain’ with very small effect size (d=-0.16, 95% CI -0.35 to 0.03). Three studies (Dishion et al. 2015 +; Green et al. 2014 -; LeCroy and Krysik 2011 +) found a significant impact of home visiting intervention on parenting behaviours including increased parental engagement (Dishion et al. 2015 +, no effect sizes reported), developmentally

supportive behaviours (d=2.96[11]) and reading (d=2.96)[12] (Green et al. 2014 -), reduced oppression of child's independence, with small effect size (d=0.28)[13] and improved safety practices, with small effect size (d=0.31)[14] (LeCroy and Krysik 2011 +). It is notable that, with the exception of the Green et al. (2014 -) study, which was rated as poor, effects on these outcomes where they are observed tend to be of small effect size.

Impact on children's health and wellbeing

1. Hospitalisation

Five of the studies considered in the Nelson et al. (2013 +) review (Barlow et al. 2007; Duggan et al. 2004, 2007; Fergusson et al. 2005; Koniak Griffin et al. 2003) looked at the impact of home visiting on visits to the emergency department or hospital admissions. For emergency department visits, 2 studies (Duggan et al. 2007, Koniak Griffin et al. 2003) found no significant difference between intervention and control groups. One study (Fergusson et al. 2005) found that fewer children in the intervention group were seen in hospital for accident/injury or accidental poisoning (OR 0.59, 95% CI 0.36 to 0.98). For hospital admissions, 4 studies found no significant difference between intervention and control group (Barlow et al. 2007; Duggan et al. 2004, 2007; Fergusson et al. 2005). One study found fewer episodes of hospitalisation in the intervention group (Koniak-Griffin et al. 2003, $p<0.01$, effect sizes not reported). The second review (Peacock et al. 2013 +) considered 1 study which looked at hospitalisation (Johnson et al. 1993) which found that there were no significant differences between intervention and control.

One moderate quality UK RCT (Robling et al. 2015 +) found that there were marginally significantly more children in the intervention group were admitted to hospital before their second birthday than those in the control group (AOR 1.32, CI 97.5% 0.99-1.76).

[11] Calculated by reviewing team.
[12] Calculated by reviewing team.
[13] Calculated by reviewing team
[14] Calculated by reviewing team

Adherence to immunisation

Three of the studies considered in the Nelson et al. (2013 +) review (El-Mohandes et al. 2003; Fergusson et al. 2005; Koniak-Griffin et al. 2003) considered adherence to immunisation. Two studies (Fergusson et al. 2005; Koniak-Griffin et al. 2003) found no significant difference between intervention and control. One study found that the intervention group were marginally significantly more likely to have received immunisations at 12 months (El-Mohandes et al. 2003, p=0.08, effect sizes not reported). One of the studies considered in the Peacock et al. (2013 +) review (Johnson et al. 1993) found that there were significantly higher rates of immunisation at 1 year in the intervention group compared to controls (p<0.01, effect size not reported).

Developmental delay

Six of the studies considered in the Peacock et al. (2013 +) review considered psychomotor and cognitive development (Black et al. 1995; Caldera et al. 2007; Cupples et al. 2011; Johnson et al. 1993; Kartin et al. 2002; Nair et al. 2003). In 3 studies there was no significant difference between intervention group and control (Black et al. 1995; Cupples et al. 2011; Kartin et al. 2002). In 3 studies the intervention group showed better development than those in the control group (Caldera et al. 2007; Johnson et al. 1993; Nair et al. 2003, no effect sizes reported).

One moderate quality UK RCT (Robling et al. 2015 +) found that marginally significantly fewer children in the intervention group had developmental concerns at 24 months (AOR 0.61, CI 95% 0.40 to 0.90) and 1 poor quality US RCT (Green et al. 2014 -) found that marginally significantly fewer parents in the intervention group had been told that their child had a developmental concern (OR=1.72, p=0.078).

Child/young person behaviour

Two of the studies considered in the Peacock et al. (2013 +) review considered child behaviour (Caldera et al. 2007; Kartin et al. 2002). In 1 study, there was no difference between groups (Kartin et al. 2002). In 1 study the intervention group showed better scores in relation to internalising and externalising behaviour (Caldera et al. 2007).

One moderate quality US RCT (DuMont et al. 2011 +) found little impact of home visiting interventions on young people's wellbeing in terms of their risk factors for delinquency. One moderate quality Dutch RCT (Mejdoubi et al. 2015 +) found that the number of children with internalising behaviour (measured by the CBCL at 24 months) was significantly lower in the intervention group than in the control group (RR 0.56; CI 95% 0.24 to 0.94), but there was no significant difference for externalising behaviour.

Impact on caregiver/parents' health and wellbeing

Impact on caregiver and parent health and wellbeing was examined in 1 moderate quality UK RCT (Robling et al. 2015 +), 1 moderate quality US RCT (LeCroy and Krysik and 1 poor quality US RCT (Green et al. 2014 -).

Robling et al. (2015 +) considered a range of outcomes in relation to parents and found a marginally significant difference in favour of the intervention group on parents' self-efficacy, with small to medium effect size (adjusted mean difference 0.44 CI 95% 0.10 to 0.78). However, no significant differences were observed for psychological distress, depressive symptoms, postnatal depression, unplanned hospital admissions or hospital attendance for the parent. LeCroy and Krysik (2011 +) found that there was significant impact on factors such as alcohol use, with small effect size (d=0.31), and maternal engagement in education or training, with small to medium effect size (d=0.39). The poor quality US RCT (Green et al. 2014 -) found that home visiting had no impact on parenting outcomes in terms of depressive symptomatology.

Impact on satisfaction with services

There was a small amount of evidence from an effectiveness study that parents have greater satisfaction with home visiting interventions provided at the early help stage, than with a standard community mental health programme. One moderate quality US RCT (Silovsky et al. 2011 +) found significantly higher levels of satisfaction with services for parents allocated to a home visiting intervention compared to those allocated to standard community mental health services. However, this did not translate to improved outcomes for children in this study.

Views and experiences

The following key themes emerged from 5 views and experiences studies (Allen 2007 +; Domian et al. 2010 +; Krysik et al. 2008 +); 1 with home visiting coaches, regarding their perceptions of parents' needs (Paris 2008 +) and 1 with a mixture of parents and providers (Stevens et al. 2005 +).

There was a set of themes in relation to what caregivers and parents value about home visiting services:

- a positive and trusting relationship with the home visitor
- the personal qualities of the home visitor, for example, being 'caring' or 'a friend'
- having a home visitor who is perceived as knowledgeable, in particular having had experience of having children
- provision of practical support, such as household support and making links to community services
- provision of support in the home, meaning that transportation is not necessary.

There was a set of themes in relation to barriers to engagement with home visiting services:

- caregivers and parents fear that the service may result in CPS involvement, particularly if they have been involved with CPS before
- caregivers and parents can perceive services to be intrusive, particularly questions asked by the home visitor at the early stages
- home visitors who are not perceived as knowledgeable – for example, who have not had children
- caregivers and parents can find it difficult if they have to make a transition to a new home visitor.

2. Parenting programmes

Description of evidence

Evidence of the effectiveness of parenting programmes was provided in 1 moderate quality systematic review of reviews (Barlow et al. 2006 +), and 2 moderate quality RCTs, 1 from the USA and 1 from Australia (Dawe and Harnett 2007 +; Sanders et al. 2004 +) (see Table 13).

Only evidence relating to programmes targeted at children at risk of abuse and neglect and their caregivers was considered. For parenting programmes, target families were usually identified via a screening process which assessed certain known risk factors such as drug abuse (for example, Dawe and Harnett 2007 +), prior notification to government agencies or parental self-concerns (for example, Sanders et al. 2004 +), parents with IQs lower than 80 or unmarried teenage mothers (Barlow et al. 2006 +).

Table 13. Study characteristics – parenting programmes

Study	Quality	n	Population	Intervention	Comparison group
Reviews included in Barlow et al. 2006 +					
Feldman (1994) Country not stated	Rated by authors as 5/9	20 studies	Parents with learning disabilities	Parenting skills programmes	Not reported
Gray and Halpern (1988) Country not stated	Rated by authors as 7/9	48 studies	Parents at risk of abuse	Parenting programmes	Not reported
Other studies					
Dawe and Harnett (2007) (USA)	Moderate	64	Parents engaged in a methadone maintenance programme with at least 1 child between the ages of 2 and 8	Parents Under Pressure	Brief intervention Standard care
Sanders et al. (2004) (Australia)	Moderate	98	Parents experiencing anger management problems in relation to their child (aged 2-7)	Enhanced Triple-P	Standard Triple-P
Stover (2015) (USA)	Poor	18	Fathers and their female co-parents referred after domestic violence and drug charges. Children aged under 10	Fathers for Change	Evidence-based individual drug counselling with fathers only

Description of intervention

The core components of parenting programmes are:

- educational interventions delivered over a relatively short period such as 10-12 weeks (e.g. Dawe and Harnett 2007 +), although some interventions were longer (for example, Stover 2015 - was 4 months)
- sessions are often thematic or delivered on a modular basis and typically focus on enhancing parenting skills, addressing negative parenting behaviours and developing coping strategies and child behaviour management techniques (for example, Barlow et al. 2006 +; Dawe and Harnett 2007m +; Sanders et al. 2004 +), attachment, family systems and cognitive behavioural theory (Stover 2015 -)
- structured delivery of sessions and use of workbooks to provide further information and record parental progress (for example, Sanders et al. 2004 +).

However, the interventions were also heterogeneous in terms of the following.

- The number of participants in each session. Some interventions were provided through individual sessions with each family (e.g. Dawe and Harnett 2007 +) while others were delivered via group sessions (e.g. Barlow et al. 2006 +).
- Reason for referral – for example, the Stover (2015 -) study focused on substance-misusing fathers with a history of intimate partner violence, the Dawe and Harnett (2007 +) study also focused on parents with substance misuse problems, whereas participants in Sanders et al. (2004 +) were experiencing difficulties in relation to their children.
- The included studies did not always make clear references to the theories of change on which the intervention was based. However, authors often refer to the concept of family environment and ecological models of child development (for example, Dawe and Harnett 2007 +; Sanders et al. 2004 +).

Comparison interventions typically consisted of ‘care as usual’ or standard parenting programmes (for example, Dawe and Harnett 2007 +; Sanders et al. 2004 +), although the content of these was not always clear (e.g. Barlow et al. 2006 +). The outcomes measured in each of the studies are given in Appendix A.

Views and experiences evidence relating to parenting programmes was provided in 1 qualitative study of moderate quality (Self-Brown et al. 2011 +). This was an American study which interviewed 11 SafeCare providers regarding the need for cultural adaptations to the model.

Narrative summary

Impact on incidence of abuse and neglect

The Stover (2015 -) study examined the impact of the intervention on incidence of intimate partner violence by the father. This has been conceptualised as incidence of abuse and neglect because witnessing domestic violence is categorised as a form of abuse. The study found a significant difference, with medium effect size (d=0.52) in favour of the intervention group in terms of rates of intimate partner violence. However, it should be noted that this is a poor quality study with a small sample size, and did not measure maltreatment focused directly on children.

Impact on risk of abuse and neglect

Three studies examined the impact of parenting programmes on risk of abuse and neglect (Dawe and Harnett 2007 +; Sanders et al. 2004 +). One moderate quality Australian RCT (Sanders et al. 2004 +) found that participants in 2 variants of behavioural family intervention based on the Triple-P Parenting Program showed significant improvements in risk of abuse and neglect. Those taking part in an enhanced version of the Triple-P Parenting Program (additional content targeted at risk factors for abuse and neglect) showed a significantly greater reduction in 2 measures of child abuse risk: child abuse potential (measured via Child Abuse Potential Inventory scores), with medium effect size (d=0.51) and unrealistic expectations scores, as measured by the Parent Opinion Questionnaire, with medium effect size (d=0.52). One moderate quality US RCT (Dawe and Harnett 2007 +) found that parents allocated to a ‘Parents Under Pressure’ parenting programme showed a significant decrease in child abuse potential (measured by Child Abuse Potential Inventory), harsh parenting and parenting stress whereas those in the standard care and brief intervention conditions did not ($p<0.01$, no effect sizes reported).

Impact on quality of parenting and parent-child relationships

One moderate quality systematic review of reviews (Barlow et al. 2006 +) found that, of the 2 included studies which measured parents' knowledge and behaviour, both showed a positive impact (Feldman 1994; Gray and Halpern 1988, cited in Barlow et al. 2006 +, no effect sizes reported). This included 1 study of an intervention aimed at parents with learning difficulties (Feldman 1994, cited in Barlow et al. 2006 +). One poor quality US RCT examining the impact of a parenting programme for substance-misusing fathers (Stover 2015 -) found a significant impact of the intervention on measures of parenting quality, including intrusiveness during play, with large effect size (d=1.32[15]) and parenting consistency, with large effect size (d=0.97[16]). One moderate quality Australian RCT (Sanders et al. 2004 +) found both variants of a behavioural family intervention based on the Triple-P Parenting Programme had a significant impact on 2 self-report measures of parenting (no effect sizes reported), although the improvement was not greater in the enhanced version of the programme.

Impact on children's and caregiver/parents' health and wellbeing

There was equivocal evidence regarding the impact parenting programmes offered at the early help stage on parents' health and wellbeing outcomes. One moderate quality Australian RCT (Sanders et al. 2004 +) found that parenting programmes had no impact on parental wellbeing as measured by the Depression-Anxiety-Stress Scales and the Parent Problem Checklist. One moderate quality US RCT (Dawe and Harnett 2007 +) found that children in the Parents Under Pressure group showed a significant improvement in behaviour measured using the Strengths and Difficulties Questionnaire ($p<0.01$, no effect size reported), which was not observed in the other 2 groups However, there were no direct between-group contrasts. The same Australian RCT (Dawe and Harnett 2007 +) found that methadone-maintained parents allocated to the 'Parents Under Pressure' intervention showed a significant decrease in methadone use ($p<0.01$, no effect size reported), whereas those in comparison interventions did not. However, there were no direct between-group

[15] Calculated by reviewing team.
[16] Calculated by reviewing team.

contrasts, making this evidence weak. Furthermore, no groups showed a reduction in alcohol use.

Impact on satisfaction with services

None of the included studies measured the impact of parenting programmes provided at the early help stage on satisfaction with services.

Views and experiences

There was evidence from 1 qualitative study (Self-Brown et al. 2011 +) that professionals providing parenting programmes:

- emphasise the importance of engagement with families in providing a foundation for the programme
- report that matching on the basis of ethnicity and language can help to improve engagement, particularly regarding language, but that lack of matching is not necessarily a barrier to engagement
- report that cultural adaptation of a parenting programme is less important than tailoring the programme to each individual family, but that it is important to cover cultural issues in staff training.

3. Parent-Child Interaction Therapy

Description of evidence

Evidence of the effectiveness of parent-child interaction therapy was provided in 2 moderate quality RCTS from Australia (Thomas and Zimmer-Gembeck 2011 +, 2012 +) and 1 from the USA (Scudder et al. 2014 +).

Only evidence relating to programmes targeted at children at risk of abuse and neglect and their caregivers was considered. For parent-child interaction therapy, target families were usually identified by referrals from government agencies or parental self-referrals (for example, Thomas and Zimmer-Gembeck 2011 +) (see Table 14).

Table 14. Study characteristics – Parent-Child Interaction Therapy

Study	Quality	n	Population	Intervention	Comparison group
Scudder et al. (2014 +) (USA)	Moderate	82	Mothers incarcerated in a state correctional facility	Parent-child interaction therapy	Existing parenting programme at the facility
Thomas and Zimmer-Gembeck (2011 +) (Australia)	Moderate	150	Mothers at a high risk of or with a history of child maltreatment referred by government agencies, identified as a 'suspect' by a professional, or self-referred	Parent-child interaction therapy	Waitlist
Thomas and Zimmer-Gembeck (2012 +) (Australia)	Moderate	151	Families at high risk of, or engaged in, maltreatment	Parent-child interaction therapy	Waitlist

Description of intervention

The core components of parent-child interaction therapy described in the papers are as follows:

- The intervention aims to improve the quality of the parent-child relationship by helping parents to understand how their behaviour affects their child as well as enhancing parenting skills by encouraging parents to use appropriate behaviour management techniques (e.g. Scudder et al. 2014 +; Thomas and Zimmer-Gembeck 2011 +).
- Sessions typically involve both the parent and child and include a combination of instruction, coaching and role play (Scudder et al. 2014 +; Thomas and Zimmer-Gembeck 2011 +). Participants may be observed through a one-way mirror.

However, the interventions also differ in terms of:

- Involvement of the child – Parent-Child Interaction Therapy is typically delivered to both parents and children, however this was not possible in the case of incarcerated mothers as reported in Scudder et al. (2014 +).

- Treatment duration – In standard parent-child interaction therapy the number of sessions which participants receive can vary as parents are required to 'master' certain techniques and skills in order to progress or graduate from the programme. In contrast, Scudder et al. (2014 +) report that mothers in this study were limited to 7 sessions ('mastery' was not required).

Thomas and Zimmer-Gembeck (2012 +) highlight the theoretical foundations for the model as relating to the fact that 'proximal risks of child maltreatment are negative and coerceive patterns of parent-child interactions and parents' lack of knowledge or inappropriate use of discipline' (p254). The intervention therefore seeks to address these risks.

Narrative summary

Impact on incidence of abuse and neglect

None of the included studies measured the impact of parent-child interaction therapy provided at the early help stage on incidence of abuse and neglect. Thomas and Zimmer-Gembeck (2011 +) were only able to compare completers versus non-completers of the intervention – we have not reported the results here as there are likely to be systematic differences between completers and non-completers. Non-completion may also have been due to problems with the programme.

Impact on risk of abuse and neglect

There was some evidence that parent-child interaction therapy offered at the early help stage does not have an impact on risk of abuse and neglect. Two moderate quality Australian RCTs (Thomas and Zimmer-Gembeck 2011 +, 2012 +) and 1 moderate quality US RCT (Scudder et al. 2014 +) found no impact of parent-child interaction therapy on measures of parental risk of abuse and neglect.

Impact on quality of parenting and parent-child relationships

Two moderate quality Australian RCTs (Thomas and Zimmer-Gembeck 2011 +, 2012 +) and 1 moderate quality US RCT (Scudder et al. 2014 +) examined the impact of the intervention on parenting quality. Thomas and Zimmer-Gembeck (2011 +) found significant differences between intervention and control on maternal sensitivity, with small to medium effect size (d=0.38), as did Thomas and Zimmer-Gembeck (2012 +), also with small to medium effect size (d=-0.47). Scudder et al.

(2014 +) found significant improvements in interaction as measured by the Dyadic Parent-Child Interaction coding system in relation to positive attention, with large effect size (d=1.67), negative attention, with large effect size (d=0.83), command sequences, with medium effect size (d=0.54) and praise with large effect size (d=1.02).

Impact on children's health and wellbeing

There was some evidence that parent-child interaction therapy at the early help stage has a positive impact on children and young people's wellbeing. One moderate quality Australian RCT (Thomas and Zimmer-Gembeck 2012 +) found significant differences in favour of the intervention group on measures of externalising (d=-0.38) and internalising behaviour (d=-.30), and child behaviour problems (d=-0.61). A second moderate quality Australian RCT (Thomas and Zimmer-Gembeck 2011 +) also found marginally significant (p=0.12) differences between groups (in favour of the intervention group) on parentally reported externalising behaviours of the child, with small to medium effect size (d=-0.40). However, there were no significant differences between groups on parental reports of internalising problems. Children in the intervention group also had significantly better scores on the Eyberg Child Behaviour Inventory in terms of intensity of problems, with medium effect size (d=-0.64) and the extent to which behaviours were perceived as problematic, with medium to large effect size (d=-0.71) .

Impact on caregiver/parents' health and wellbeing

There was equivocal evidence that parent-child interaction therapy at the early help stage had a positive impact on parents' wellbeing. One moderate quality Australian RCT (Thomas and Zimmer-Gembeck 2011 +) found that parents in the treatment group showed significantly better parental stress scores at treatment completion, with medium effect size (d=-0.50). However, a second moderate quality Australian RCT (Thomas and Zimmer-Gembeck 2012 +) found no significant differences in parental stress or depression.

Impact on satisfaction with services

One moderate quality US RCT (Scudder et al. 2014 +) found that parents who participated in parent-child interaction therapy had higher satisfaction with services than those in the comparison group, with a medium effect size (d=0.50).

4. Multimodal interventions

Description of evidence

Evidence of the effectiveness of multimodal interventions was provided in 1 moderate quality systematic review of reviews (Barlow et al. 2006 +), 2 RCTs of moderate quality (Carta et al. 2013 +; Lam et al. 2009 +) and 1 RCT of poor quality reported in 2 papers (DePanfilis and Dubowitz 2005 -; DePanfilis et al. 2008 -) (see Table 15).

Table 15. Study characteristics – Multimodal Interventions

Study	Quality	n	Population	Intervention	Comparison group
Reviews cited in Barlow et al. 2006 +					
Edgeworth and Carr (1999)	Rated by authors as 5/9	11 studies	Abusive parents/families	Project 12 ways	Not reported
Other studies					
Study 1. Carta et al. (2013 +) (USA)	Moderate	371	High risk mothers of 3.5- to 5.5-year-old children	Planned activities training (PAT) – a manualised component of the SafeCare parent training model, plus phone-based support	Standard intervention (without phone support) Waitlist
Study 2. Reported in DePanfilis and Dubowitz (2005 -) and DePanfilis et al. (2008 -) (USA)	Poor	125	Families at risk of child neglect with children aged between 5 and 11	Family Connections – higher 'dosage' (9 months)	Family Connections – lower 'dosage' (3 months)
Study 3. Lam et al. (2009 +) (USA)	Moderate	30	Heterosexual couples in which the male was entering alcohol abuse treatment	Parent training with behavioural couples therapy	Individual-based treatment
Study 4. Pereira et al. (2014 -) (Portugal)	Poor	43	Mothers of 1- to 4-year-olds, known to health and social care services for whom there are concerns about the	Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline	Phone support

			caregiving environment	(home visiting with video feedback)	

Description of intervention

Barlow et al. (2006 +) describe multimodal interventions as those comprising a range of components including a mixture of 'family support, preschool education or childcare and community development'. We have used this term to refer to any interventions which combine 2 or more treatment modalities, for example:

- home visiting plus additional phone-based support (Carta et al. 2013 +)
- home visiting plus video feedback (Pereira et al. 2014 -)
- parenting training plus couples therapy (Lam et al. 2009 +).

Only evidence relating to programmes targeted at children at risk of abuse and neglect and their caregivers was considered. For multi-component interventions families were usually targeted through a risk assessment process focusing on factors such as mothers younger than 18 or low educational status, while another intervention was offered to fathers participating in an alcohol treatment programme.

Narrative summary

Impact on incidence of abuse and neglect

Impact on abuse and neglect was considered in 1 systematic review of reviews (Barlow et al. 2006 +), which reports a review of Project 12-Ways which showed a positive impact on incidence of abuse and neglect during the 5 years that the programme was delivered (Edgeworth and Carr 1999, cited in Barlow et al. 2006 +). One moderate quality US RCT (Lam et al. 2009 +) reported the positive impact of a multimodal intervention (parenting training combined with behavioural couples therapy) on incidence of abuse and neglect, measured via CPS report ($r>0.2$).

However, 1 poor quality US RCT (DePanfilis et al. 2005 -) found that a multimodal intervention comprising a) emergency assistance, b) home-based family intervention (family assessment, outcome driven service plans, individual and family counselling), c) service coordination with referrals targeted towards risk and protective factors, and d) multifamily supportive recreational activities had no impact on incidence of

abuse and neglect. A poor quality Portuguese RCT (Pereira et al. 2014 -) found there was no overall relationship between participation in an intervention combining home visiting with video feedback and harsh discipline, although a significant intervention effect of medium effect size (partial eta squared =0.13) was observed for parents showing higher initial levels of parenting stress.

Impact on risk of abuse and neglect

There was a small amount of evidence that multimodal interventions offered at the early help stage decrease parental risk of abuse and neglect. One moderate quality US RCT (Carta et al. 2013 +) found evidence that a parenting intervention enhanced with ongoing contact via mobile phone was more effective in reducing risk of abuse and neglect than the standard intervention or waitlist control, with small effect size (d=0.27). One poor quality US RCT (DePanfilis et al. 2005 -) found significant improvements in the higher dosage intervention group compared to lower dosage in caregiver depressive symptoms (d=0.32),[17] but not for the Difficult Child and Parental Distress subscales of the Parenting Stress Index and measures of everyday stress. However, it should be noted that this study did not include a 'no service' or 'usual service' control, but rather 2 treatment groups receiving different lengths of intervention.

Impact on quality of parenting and parent-child relationships

There was a small amount of evidence that multimodal interventions provided at the early help stage have an impact on quality of parenting. One review reported in a systematic review of reviews (Barlow et al. 2006 +) found that outcomes such as parental knowledge, attitudes and behaviour (both self-reported and observed) showed that while some of these interventions were moderately effective (for example, hospital-based perinatal programmes, ES: 0.34; perinatal coaching with home visiting, ES 0.29; and agency counselling, ES: 0.38), others were ineffective (for example, perinatal coaching with support group, and support groups alone) (Gray and Halpern 1988, cited in Barlow et al. 2006 +). Two moderate quality US RCTs (Carta et al. 2013 +; Lam et al. 2009 +) found that parents allocated to 1) a mobile-phone enhanced parenting programme and 2) a combination of parenting

[17] Calculated by reviewing team.

skills with behavioural couples therapy showed significantly improved parenting compared to a control group (d=0.46 and r>0.30[18] respectively).

Impact on children's health and wellbeing

There was equivocal evidence regarding the impact of multimodal interventions provided at the early help stage on children's wellbeing. One moderate quality US RCT (Carta et al. 2013 +) found that children whose parents were involved in either variant of the Planned Activities Training parenting intervention showed greater rates of positive engagement (d=0.43), but there was no difference in maternal ratings of children's internalising or externalising behaviours. Another poor quality US RCT (DePanfilis et al. 2005 -) found that higher 'dosage' of the Family Connections programme led to greater improvements in child internalising behaviour, with small effect size (d=0.34), but not externalising behaviour.

Impact on caregiver/parents' health and wellbeing

There was a small amount of evidence that multimodal interventions have a positive impact on parental wellbeing. One moderate quality US RCT (Carta et al. 2013 +) found that parents taking part in a mobile-phone enhanced variant of the Planned Activities Training parenting intervention had significantly better depression scores than a waitlist control, with a small to moderate effect size (d=0.31).

Impact on satisfaction with services

None of the included studies measured the impact of multimodal intervention offered at the early help stage on satisfaction with services.

5. Intensive Family Preservation Services

Description of the evidence

Evidence of the effectiveness of Intensive Family Preservation Services (IFPS) was provided in 1 moderate quality systematic review of reviews (Barlow et al. 2006 +) (see Table 16).

[18] Refers to effect size for Parental Monitoring Scale scores for mothers (more conservative value).

Table 16. Study characteristics – Intensive Family Preservation Services

Study	Quality	n	Population	Intervention	Comparison group
Reviews cited in Barlow et al. 2006 +					
Dagenais et al. (2004)	Rated by authors as 6/9	27 studies	Abusive parents/families	Project 12 ways	Not reported

The core components of IFPS are reported in Barlow et al. as:

- short-term interventions delivered in the home
- sessions can include family therapy, parental support and training in 'life skills', behavioural management.

Barlow et al. report that this is a targeted service, although the method for targeting is not reported. Comparison interventions are not also reported.

Narrative summary

The review of reviews (Barlow et al. 2006 +) reports 1 included review (Dagenais, 2004 reported in Barlow et al. 2006 +) which found that IFPS had a positive impact on maltreatment (effect size not reported), although not on out-of-home placement, and also that it had a positive impact on child and family functioning (effect size not reported).

6. Social support and other interventions

Description of the evidence

Evidence of the effectiveness of social support and other interventions was provided in in 1 moderate quality systematic review of reviews (Barlow et al. 2006 +) (see Table 17).

Table 17. Study characteristics – social support and other interventions

Study	Quality	n	Population	Intervention	Comparison group
Reviews cited in Barlow et al. 2006 +					
Clark et al. (2000)	Rated by authors as 7/9	2782 studies	Parents at high risk of being 'less than optimal parents'	Social support	Not reported

Social support programmes are defined in the paper as programmes often designed to help parents strengthen their social networks and enhance their wellbeing. Sessions could be delivered in both group format or individually and the duration of treatment often varied. While many interventions were generally aimed at supporting parents to enhance their wellbeing, some programmes also included an element of structured training which targeted negative parenting behaviours.

The theoretical foundations of the interventions are not reported by the review. Comparison interventions are also not reported.

Narrative summary

One moderate quality systematic review of reviews (Barlow et al. 2006 +) reports 1 included review (Clark 2000 cited in Barlow et al. 2006 +) which found that social support interventions had an impact on abuse and neglect, although this is of low effect size (ES 0.11). They also had some impact on child development, the home environment and parental knowledge and attitudes, but again these are all of low effect size (ES 0.09, 0.23 and 0.14 respectively). This review is also somewhat dated.

7. Clinic-based interventions

Description of evidence

Evidence of the effectiveness of clinic-based interventions was provided in 1 moderate quality systematic review (Nelson et al. 2013 +) (see Table 18).

Only evidence relating to programmes targeted at children at risk of abuse and neglect and their caregivers was considered. For the clinic-based intervention considered by Nelson et al. (2013 +) this population was identified via risk assessment, although details on this process are not provided in the review.

Table 18. Study characteristics – clinic-based interventions

Study	Quality	n	Population	Intervention	Comparison group
Studies reported in Nelson et al. 2013 +					
Dubowitz et al. (2009) (USA)	Rated by authors as fair	558	Families assessed as at risk	Safe Environment for Every Kid (SEEK) model	Usual care

Description of intervention

The core components of the clinic-based intervention considered by Nelson et al. (2013 +) are:

- training of paediatricians to identify and address risk factors associated with abuse and neglect
- provision of information to parents and referrals to other services where necessary
- assistance provided by a clinic-based social worker.

The review does not report the theoretical basis for the intervention. The comparison intervention consisted of 'care as usual' (that is, standard paediatric care and access to a clinic-based human services worker).

Narrative summary

One systematic review (Nelson et al. 2013 +) reports 1 trial of 729 participants (Dubowitz et al. 2009), which found that families in the intervention group had fewer CPS reports than a usual care group up to 44 months after the intervention (no effect sizes reported), and that parents in the intervention group reported fewer episodes of severe or very severe physical assault than usual care parents (no effect sizes reported). It also found that parents in the intervention group showed fewer instances of nonadherence to medical care and fewer delays in immunisations (no effect sizes reported).

Economics

Notes to assist in interpreting economic evidence

It is important to note that cost-effectiveness results from non-UK studies will have limited applicability to inform UK practice. This is due to differences in the unit costs of services and differences in the institutional context and corresponding patterns of service use. The implication is that the monetary results from non-UK studies do not provide conclusive evidence but they can provide an indication about cost-effectiveness for the UK context. In order to be conclusive about cost-effectiveness results, non-UK research would need to be replicated in the UK.

Summary of economic evidence

The evidence identified for review question 9 included 1 systematic review of economic evaluations from a range of countries and 5 RCTs, including an economic evaluation of which 1 was a decision model. Two RCTs were from the UK, 2 were from the USA, and 1 was from Australia. Four studies evaluated home visiting interventions and the fifth evaluated a parenting programme. We also undertook new economic analysis, which focused on home visiting interventions.

Narrative summaries of home visiting interventions

1. Systematic review

The systematic review of economic evaluations focused on home visiting programmes for vulnerable pregnant women (Stamuli et al. 2015 ++). The review contains 12 RCTs of which 1 is a UK study that we have reviewed in detail (see Barlow et al 2007 +), 1 Chilean study, and 10 US studies, of which some US studies were re-analyses of the same data.

The US and Chilean studies' cost-effectiveness results have limited applicability to the UK for the reasons discussed above. Furthermore, these studies take a narrow cost perspective. These studies' designs were of variable quality. The US and Chilean studies found that the home visiting intervention resulted in better outcomes.

The Chilean study found that the intervention led to improvements in the mother's mental health and that it resulted in a net cost increase to the Chilean government from the perspective of health services, measured over a 15-month period.

The US studies found that the various home visiting interventions led to improvements in outcomes and net cost savings to the government. The US studies' evaluation of costs focused on the government perspective, including welfare payments and tax income. Another study looks at reductions in government costs due to reduced crime. In some US studies the intervention led to reductions in welfare payments either as a result of increased employment rates and income from participating mothers or a larger proportion of children graduating from high school and having higher test scores. One US study found that the intervention led to a reduction in crime for both mother and child and reductions in alcohol and substance abuse.

In most studies (UK and non-UK), the time horizon of the economic analysis is limited to the period of the intervention, rather than covering a life-course perspective. A life-course perspective is more appropriate if we assume that the effects of the intervention may occur later, rather than immediately. If this were the case, then the evaluation would not have captured the longer-term benefits and costs. This means that the cost-effectiveness results of the studies might have changed had the time horizon been longer.

In conclusion, the authors of the systematic review believe that most of the studies, while informative in some ways, do not provide adequate information on which to base UK practice.

2. UK RCTs

One UK RCT (n=131) (Barlow et al 2007 +) evaluates the 'Family Partnership Model'. This evidence is directly applicable to the review question. The economic methodology is rated as 'good' because it takes a wide cost perspective (includes health, social care, legal, housing). Costs reflect 2004 prices.

The UK RCT includes participants who are young, first-time, expectant mothers, aged 19 years and younger. The intervention provides intensive home visiting in the 6 months of the antenatal period and continues for a further 12 months during the postnatal period (a mean total of 41 visits over the 18-month period). The intervention is compared to participants in the comparator arm who receive standard care, which includes health visiting, but less intensively (a mean total of 10 visits over the 18-month period).

The economic evaluation takes a societal perspective (health service, social services, legal and housing costs) using a retrospective self-report survey. The economic evaluation reports total costs and does not disaggregate different cost categories. Appropriate statistical analyses were used to account for uncertainty surrounding total costs. Primary and secondary outcomes included incidence of abuse and neglect, risk of abuse and neglect using parental and home indicators, and children's health and wellbeing outcomes. The evaluation measured costs and outcomes over an 18-month period.

The evaluation found that the intervention led to an increase in total net costs (from a societal perspective) at the end of the 18-month period and an improvement in 2 of the primary outcomes (maternal sensitivity to their infant and infant cooperativeness) at 12 months post-childbirth. The mean additional cost of the home visiting intervention, relative to standard care home visiting is £2,330.51 (sd=36.33) per mother.

Total societal costs were £7,120 for the intervention and £3,874 for the control arms (inclusive of intervention costs). The bootstrapped mean increase in total net costs to society as a result of the intervention was £3,246 per mother (95% CI=1645–4,803). NHS services accounted for 72% of costs (£2,361) due to increased psychologist appointments (p=0.028) and phone calls to the health visitor (p=0.019) and a non-significant increase in visits to a hospital midwife (p=0.16). However some NHS service use decreased as a result of the intervention, including clinic visits to the health visitor (p=0.01) and a non-significant decrease in the use of A&E visits for the infant (p=0.10). The remaining cost increase (£885) was a result of increased use of child protection services (personal social services and housing services). These stemmed from a non-significant increase in the number of intervention children entering foster care or adoption (p=0.15).

A second UK RCT (n=1,645) evaluates the 'Family Nurse Partnership' intervention (Robling et al 2015 +). This is compared to participants receiving 'standard care' services. This is provided to pregnant women (<25 weeks gestation) aged 19 years or younger on their first pregnancy. The study design was rated as (+). The study is directly applicable to the UK context but the economic evaluation has some limitations. Authors report that the perspective of analysis is that of health and social care services, but they provide very little information about economic methods, including what types of resources were included in the analysis and source of unit costs. Therefore, due to poor reporting, it is unclear whether economic methods are comprehensive or partial, and this means that the incremental costs between services may not be accurate. Furthermore, total costs are presented without a breakdown into different cost categories (that is, hospital vs community healthcare).

The evaluation finds that, in the short-term (24 months), the intervention is no better than standard care services in relation to primary outcomes measured. For those

primary outcomes, the intervention costs more and does not improve outcomes, so it is not cost-effective. The primary outcomes included biomarker-calibrated self-reported tobacco use by the mother at late pregnancy, birth-weight of the baby, proportion of women with a second pregnancy within 24 months post-partum, and emergency attendances and hospital admissions for the child within 24 months post-partum.

However, the evaluation found that the intervention did better than standard care services for some of the secondary outcomes and so the intervention is cost-effective for those secondary outcomes. Favourable findings for the intervention group included small positive impacts on intention-to-breastfeed, maternally reported child cognitive development (at 24 months), language development using maternal self-report (at 12 and 18 months) and language development when measured with a standardised assessment (at 24 months), levels of social support, partner-relationship quality and general self-efficacy. The intervention also found that there were higher rates of documentation for child safety concern but the authors believe this may be a result of surveillance bias.

Price year of costs is not reported. The total incremental cost of the intervention is £1,993 per participant (price year not reported) (when using multiple imputation to deal with missing data). In a sensitivity analysis which uses ‘complete case analysis’ for dealing with missing data, the cost per participant increases to £4,670 (95% CI, £332 –£6,017) per participant. These costs are net of changes in the use of NHS and PSS services.

In the medium to long term, the cost-effectiveness of the intervention might change if we assume lagged intervention effects, for example, positive changes in secondary outcomes in the short-term (that is, child’s language development and mother’s level of social support, self-efficacy, partner-relationship quality) may result in knock-on effects on other health or social-care related outcomes. At this point it is unclear but further research is needed to follow-up the child at an older age.

3. US RCTs

Two US RCTs were identified and their cost-effectiveness results have limited applicability to the UK context.

The first US RCT (n=154) is rated as having a poor study design (DePanfilis and Dubowitz 2005; DePanfilis et al. 2008 -). This RCT includes low socioeconomic families referred from the community based on home, child and family indicators, and includes children of all ages (mean age 8, range newborn to 20 years old).

The intervention builds on the key principles of home visitation and includes a multi-faceted community-based service that works with families in their neighbourhoods to help them meet the basic needs of their children. The core components of the programme include '(1) emergency assistance, (2) home-visiting family intervention (family assessment, outcome-driven service plans, individual and family counselling); (3) advocacy and service coordination with referrals targeted toward risk and protective factors; and (4) multi-family supportive and recreational activities' (DePanfilis et al. 2008 -, p340).

This US evaluation compares a 9-month version of the intervention compared to a 3-month version of the intervention. The evaluation measures the impact on the incidence of abuse and neglect, risk of abuse and neglect using parent indicators, and children's health and wellbeing outcomes. Outcomes are measured at baseline and 6 months post-service closure. The evaluation only measures intervention costs only. It does not measure changes in wider service use.

Of the 10 outcomes measured, only 2 were statistically different, favouring the 9-month intervention for reductions in caregiver-reported child externalising and internalising behaviour (using the Child Behaviour Checklist) and parental depression (as measured using the Center for Epidemiologic Studies Depressed Mood Scale).

The total cost of the 3-month intervention is calculated to be $1,821 per family and the cost of the 9-month intervention is $4,194 per family. Costs reflect the 2000 price-year.

The second US RCT (n=897) is rated as having a good study design (DuMont et al. 2011 ++). This RCT includes mothers of infants aged less than 3 months and analyses a subgroup of expectant mothers who receive the intervention during the antenatal period (n=179) and a subgroup of mothers who have a history of abuse

and neglect and were targeted for recurrence prevention (n=104). Included families were those scoring 25+ points on the Kempe Family Stress Checklist.

The intervention is an intensive home visitation programme compared to standard care services (receiving information and referral to appropriate services other than home visiting). The average length of participation in the intervention was nearly 2 years (20.68 months, sd=18.47) receiving a mean of 33 visits (sd=30.64).

The evaluation measures the impact on the incidence of abuse and neglect and child's education outcomes at 7 years follow-up. The evaluation takes a government perspective on costs, including changes in productivity (government tax revenue and mother's earned income) and use of government welfare services (food stamps, public assistance payments, the use of preventative services, child protective service investigations, and some healthcare service use). However, not all healthcare service use was measured; only the hospital costs associated with infant birth are included. The inclusion of preventative services is not clearly reported due to difficulties with data collection and unclear definitions. Preventative service use was estimated and has some potentially serious limitations. Costs reflect the 2000 price-year.

In summary, at 7-year follow-up, there were no statistical differences in total costs between the intervention and comparison groups for the whole sample (tax revenues, p=0.69, government programmes, p=0.53) and for the subgroup of young, first-time expectant mothers (tax revenues, p=0.96, government programmes, p=0.66). However for the subgroup of mothers targeted for recurrence prevention there was a non-significant decrease in the use of government programmes (p=0.12) and no differences in tax revenues (p=0.34).

The mean cost of the intervention for the whole sample is estimated to be $4,619, compared to $518 for families in the comparator group.

At 7-year follow-up, for the whole sample and the subgroup of young, first-time expectant mothers, the impact of the intervention is less clear for the incidence of abuse and neglect. This was measured by mother's self-report data, finding reductions in the mother's rate of psychological aggression and frequency of serious physical abuse (whole sample) and frequency and rates of non-violent discipline and

frequency of serious physical abuse (young, first-time expectant mothers), but these conflicted with findings of no differences as reported by the child. However, there were reductions in the prevalence of mothers using minor physical aggression (young, first-time expectant mothers). There were also no differences in the use of child protective services using administrative data. However, the evaluation found that the intervention results in better educational outcomes at 7-year follow-up. Better educational outcomes included a higher percentage of intervention children in a gifted programme, lower percentage repeating a grade, and lower percentage with a receptive vocabulary below the average.

For the subgroup of mothers targeted for recurrence prevention, the intervention resulted in reduced incidence of abuse and neglect. This was measured by reductions in cumulative rates of confirmed child welfare reports for all types of abuse and neglect, reductions in reports where the mother was the confirmed subject, reductions in the cumulative rates of confirmed reports of physical abuse, and reductions in the mean numbers of confirmed reports of all types of abuse and neglect, and reduction in the initiation of child welfare services. There were no differences in the rates of foster care placements.

De novo economic modelling, home visiting interventions

Introduction

The Guideline Committee was interested in conducting economic modelling on home visiting interventions for families at risk of abuse and neglect. Prior to undertaking any economic modelling, we undertook further analysis to determine whether modelling was appropriate, given the available data. Economic modelling is appropriate when 2 conditions are met: first, we are clear about the intervention's effect and second there is information on resource use (costs). If we cannot be sure the intervention is effective then economic modelling is not appropriate. Our analysis investigated whether the effectiveness evidence is conclusive in relation to the primary outcome of incidence of abuse and neglect, defined as substantiated cases of abuse and neglect, self-reported abuse and neglect, or observed measures of abuse and neglect. Our analysis also investigated whether the effectiveness evidence is conclusive in relation to the secondary outcome of risk factors for abuse

and neglect (for example, depression, stress, family functioning, general wellbeing, etc.).

The evidence review by the Systematic Review Team indicated that the impact of home visiting on the primary and secondary outcomes was mixed, and that the studies' samples were heterogeneous. This report examines whether the findings would be stronger if the samples were re-categorised to reduce variability. We aimed to distinguish samples by members' previous involvement in child protective services; the literature indicates this may influence intervention effectiveness. We also grouped studies into 3 distinct categories: primary prevention, secondary prevention and mixed prevention.

Methods

We undertook further analysis on the same studies identified by the Systematic Review Team. We extracted data on sample characteristics, length of follow-up, primary and secondary outcomes, and the measurement tool used. This would help us understand whether it is appropriate to compare the studies' findings.

Results

Twelve studies were included of which 3 reported results by subgroup (Lowell et al. 2011 -; DuMont et al. 2008, 2011 ++; Zielinski et al. 2009 +). This meant the primary prevention category had 6 sets of results, the secondary prevention category had 2 sets of results, and the mixed prevention category had 9 sets of results.

Despite the new analyses, the evidence on effectiveness for question 9 remains inconclusive. It is not appropriate to undertake economic modelling.

In relation to the primary outcome, for the outcome of substantiated cases of abuse and neglect, the evidence is inconsistent and the studies' samples are not comparable. For self-reported abuse and neglect, the evidence was inconclusive, mainly because measurement tools were not comparable, and none of the studies found reductions in the same type of abuse or neglect. Again, samples were not comparable. Observed abuse and neglect was rarely measured. In relation to the secondary outcomes, the evidence on reducing the risk factors of abuse and neglect was also inconclusive because few studies measured the same outcome or used the same measurement tool.

In conclusion, an economic model based on the primary or secondary outcome would not be useful. The evidence on effectiveness is either equivocal or there is insufficient information to be certain of the intervention's effect, for whom it is effective, and over what time period it is effective. Difficulties in interpreting the evidence base remain due to the mix of sample characteristics, different intervention and comparison services, and varying lengths of follow-up. Generalising results from this evidence base is difficult.

The full economic report is available in Appendix C.

Narrative summaries of parenting interventions

1. Australian RCT and decision model

One Australian RCT (n=64) evaluates the impact of a 20-week 'Parents Under Pressure' (PUP) programme compared to 2 combined comparison groups: 'Usual Care' services and a 'Brief Intervention' service (Dalziel et al. 2015 +). The Brief Intervention service is an active service providing 2 parenting sessions. The study includes substance-misusing parents who are on methadone maintenance treatment. Children of all ages are included.

At 6 months follow-up, the RCT measures changes in parents' risk of abuse, using the Child Abuse Potential Inventory (CAPI). The evaluation found that the intervention led to a 20% reduction in the rate of expected abuse. The authors attempt to estimate the long-term cost-effectiveness of intervention using a decision model. The primary outcome of the decision model is the number of abused versus non-abused children as measured over the course of the child's lifetime. The analysis is based on the assumption that the percentage of parents who no longer abuse their child, when measured at 6 months follow-up, remain that way throughout and that none of these parents revert to abusing their child. The analysis was done by converting parents' scores on the CAPI and categorising them into 'high risk' of abuse (CAPI>215, 87% likelihood of abuse), 'moderate risk' (CAPI between 166 and 215, 80% abuse likelihood), and 'low risk' (CAPI<166, assumed 0% likelihood of abuse). The costs in the analysis are based on the economic cost of a maltreated child as estimated from the research literature. The analysis also includes the cost of the intervention and the costs of screening and enrolment.

The results of their analysis find that the intervention results in a societal net cost savings of AU$31,100 per family (in the base case scenario). Price year of costs is not clear. The implication of their analysis is that the costs of the PUP programme, estimated to be AU$8,777 per family, result in societal cost-savings in the long-term. However, the cost-effectiveness result from this evaluation has very limited applicability to inform UK practice because it makes the major assumption that parents who are measured as no longer being at risk of abusing their child at 6-months follow-up remain so over the child's life course. The analysis did not test the sensitivity of the results to this major structural assumption; especially this assumption was not supported by any data. This is a very serious limitation and introduces a lot of uncertainty to the results.

There are other limitations to the economic evaluation but these are relatively less serious. The lifetime societal cost of child maltreat is based on additional literature but the quality of those estimates are unknown. However, the societal costs do include a wide range of costs and seems to be comprehensive. We are not provided with sufficient information about the methods in estimating those lifetime societal costs so we cannot be sure about its quality and applicability to the UK context. Furthermore, UK and Australian unit costs are different so the economic findings are not directly transferrable. In summary, the findings from this economic modelling study cannot be used to inform practice and policy decisions in the UK.

Full reports of economic analyses and data tables are provided in Appendix C.

Evidence statements

ES1	**ES1. Home visiting provided to families at risk of abuse and neglect – impact on incidence of abuse and neglect** This evidence statement is based on findings from 1 moderate quality review of reviews (Barlow et al. 2006 +), 2 moderate quality systematic reviews (Nelson et al. 2013 +; Peacock et al. 2013 +), 1 moderate quality UK trial (Robling et al. 2015 +), 1 moderate quality Dutch trial (Mejdoubi et al. 2015 +), 6 moderate quality US RCTs (Dishion et al. 2015 +; DuMont et al. 2011 +; Guterman et al. 2013 +; LeCroy and Krysik 2011 +; Silovsky et al. 2011 +; Zielinski et al. 2009 +) and 1 poor quality US RCT (Green et al. 2014 -). There was equivocal evidence regarding the impact of home visiting interventions targeted at the early help stage on incidence of abuse and neglect (i.e. prevention of abuse and neglect). One review of reviews (Barlow et al. 2006 +) found a small amount of evidence of positive impact

	on incidence of abuse and neglect (1 review – Bilukha et al. 2005), 1 RCT found a significant impact of home visiting on rates of referral (Mejdoubi et al. 2015 +) and 3 RCTs (Dishion et al. 2015+; DuMont et al. 2011 +; LeCroy and Krysik 2011 +) found impact on some, but not all measures. However, in 1 systematic review (Nelson et al. 2013 +) the majority of included studies showed no impact of home visitation on incidence of abuse and neglect, a second systematic review (Peacock et al. 2013 +) found equivocal evidence and 2 RCTs (Silovsky et al. 2011 +; Zielinski et al. 2009 +) found no impact on any measures of incidence of overall maltreatment. One moderate quality UK RCT (Robling et al. 2015 +) found that rates of safeguarding processes were significantly higher among those in the Family Nurse Partnership group (AOR 1.85, CI 95% 1.02 to 2.85). Surveillance bias was a significant methodological challenge in many studies. There was evidence from 1 RCT (Zielinski et al. 2009 +) that home visiting may have greater effectiveness on incidence of neglect than other types of abuse. Two RCTs (DuMont et al. 2011 +; Zielinski et al. 2009 +) provided a small amount of evidence that home visiting provided at the early help stage has greater impact on incidence of abuse and neglect for families with higher levels of risk.
ES2	**ES2. Home visiting provided to families at risk of abuse and neglect – impact on risk of abuse and neglect and quality of parenting** This evidence statement is based on a moderate quality review of reviews (Barlow et al. 2006 +), 1 moderate quality UK RCT (Robling et al. 2015 +), 1 moderate quality Dutch RCT (Mejdoubi et al. 2015 +), 4 moderate quality US RCTs (Dishion et al. 2015 +; Guterman et al. 2013 +; LeCroy and Krysik 2011 +; Silovsky et al. 2011 +) and 1 poor quality US RCT (Green et al. 2014 -). There is some evidence of mixed quality that home visiting interventions targeted at the early help stage decrease parental risk of abuse and neglect and improve parenting. Two of the included reviews considered in the review of reviews (Elkan et al. 2000; Geeraert et al. 2004 cited in Barlow et al. 2006 +) found evidence for impact on various outcomes associated with abuse and neglect including parenting skills, parental risk reduction (ES=0.33) and family functioning (ES=0.33). Two studies (Guterman et al. 2013+; Silovsky et al. 2011+) found no difference between intervention and control on a range of measures. One study (Green et al. 2014 -) found a marginally significant (p=0.057) impact of home visiting on parenting stress (effect size not reported). Three studies (Dishion et al. 2015 +; Green et al. 2014 -; LeCroy and Krysik 2011 +) found a significant impact of home visiting intervention on parenting behaviours including increased parental engagement (Dishion et al. 2015 +, no effect sizes reported), developmentally supportive behaviours, with large effect size (d=2.96) and reading, with large effect size (d=2.96) (Green et al. 2014 -), reduced oppression of child's independence, with small effect size (d=0.28) and improved safety practices, with small effect size (d=0.31) (LeCroy and Krysik 2011 +). One study (Robling et al. 2015 +) found a marginally significantly (p=0.11) lower 'parental role strain' with very small effect size (d=-0.16, 95% CI-0.35 to 0.03).
ES3	**ES3. Home visiting provided to families at risk of abuse and neglect – impact on child and caregiver/parent wellbeing** This evidence statement is based on 2 systematic reviews (Nelson et al. 2013 +; Peacock et al. 2013 +), 1 moderate quality UK RCT (Robling et al. 2015 +), 1 moderate quality Dutch RCT (Mejdoubi et al. 2015 +), 3 US

	RCTs, 2 moderate (DuMont et al. 2011 +; LeCroy and Krysik 2011 +) and 1 of poor quality (Green et al. 2014 -). These studies found equivocal evidence of impact of home visiting interventions targeted at the early help stage on children or caregiver/parents' health and wellbeing. Across the 2 systematic reviews, the majority of trials showed no impact on measures of child health and wellbeing relating to hospitalisation, and an additional RCT found higher rates of hospitalisation in the intervention group (Robling et al. 2015 +, AOR 1.32, CI 97.5% 0.99-1.76). There was equivocal evidence regarding compliance with immunisations, with 2 studies finding non-significant impact and 2 finding significant impact (El-Mohandes et al. 2003, cited in Nelson et al. 2013 +, effect size not reported; Johnson et al. 1993, effect size not reported), and on developmental delay, with 3 studies showing no impact (Black et al. 1995; Cupples et al. 2011; Kartin et al. 2002, cited in Peacock et al. 2013 +) and 5 studies showing impact (Caldera et al. 2007; Johnson et al. 1993; Nair et al. 2003, cited in Peacock et al. 2013 + no effect sizes reported; Green et al. 2014 -, OR=1.72, Robling et al. 2015 +, AOR 0.62 , CI 95% 0.40 to 0.90). One moderate quality UK RCT (Robling et al. 2015 +) found no impact on the majority of parental wellbeing outcomes, with the exception of self-efficacy with small to medium effect size (adjusted mean difference 0.44 CI 95% 0.10 to 0.78). One poor quality US RCT (Green et al. 2014 -) found that home visiting had no impact on parenting outcomes in terms of depressive symptomatology, but 1 moderate quality US RCT (LeCroy and Krysik 2011 +) found that there was significant impact on factors such as alcohol use and maternal engagement in education or training.
ES4	**ES4. Acceptability of home visiting services provided to families at risk of abuse and neglect** This evidence statement is based on 1 US RCT (Silovsky et al. 2011 +) and 5 US qualitative studies (Allen 2007 +; Domian et al. 2010 +; Krysik et al. 2008 +; Paris 2008; Stevens et al. 2005 +). This evidence suggested that caregivers and parents value home visiting services provided at the early help stage. One moderate quality US RCT (Silovsky et al. 2011 +) found significantly higher levels of satisfaction with services for parents allocated to a home visiting intervention compared to those allocated to standard community mental health services. The 5 qualitative studies (Allen 2007 +; Domian et al. 2010 +; Krysik et al. 2008 +; Paris 2008; Stevens et al. 2005 +) showed that caregivers and parents value: a positive and trusting relationship with the home visitor; the personal qualities of the home visitor, for example being 'caring' or 'a friend'; having a home visitor who is perceived as knowledgeable, in particular having had experience of having children; provision of practical support, such as help provision of household support and making links to community services; and provision of support in the home, meaning that transportation is not required.
ES5	**ES5. Barriers to families at risk of abuse and neglect in accessing home visiting services** Five good quality US qualitative studies (Allen 2007 +; Domian et al. 2010 +; Krysik et al. 2008; Paris 2008 +; Stevens et al. 2005 +) showed that barriers to families accessing and engaging in home visiting services provided at the early help stage include: concerns that this will lead to child protection services involvement; perceptions that the service is intrusive and/or that home visitors are insufficiently knowledgeable; and difficulty making a transition to new home visitors.

ES6	**ES6. Parenting programmes provided to families at risk of abuse and neglect – impact on incidence and risk of abuse and neglect** This evidence statement is based on 1 moderate quality US RCT (Dawe and Harnett 2004 +), 1 moderate quality Australian RCT (Sanders et al. 2004 +) and 1 poor quality US RCT (Stover 2015 -). One study (Stover 2015 -) found a significant difference, with medium effect size (d=0.52) in favour of the intervention group in rates of intimate partner violence. However, it should be noted that this is a poor quality study with a small sample size, and did not measure maltreatment focused directly on children. Two RCTs found evidence that parents taking part in parenting programmes at the early help stage showed a reduction in child abuse risk as measured by the Child Abuse Potential Inventory (Dawe and Harnett 2007, p<0.01, no effect sizes reported; Sanders et al. 2004 +, d=0.51).
ES7	**ES7. Parenting programmes provided to families at risk of abuse and neglect – impact on quality of parenting and parent-child relationships** There is evidence from 1 systematic review of reviews (Barlow et al. 2006 +), 1 moderate quality Australian RCT (Sanders et al. 2004 +) and 1 poor quality US RCT (Stover 2015 -) that parenting programmes provided at the early help stage have a positive impact on quality of parenting knowledge and behaviour. One poor quality US RCT examining the impact of a parenting programme for substance-misusing fathers (Stover 2015 -) found a significant impact of the intervention on measures of parenting quality including intrusiveness during play, with large effect size (d=1.32) and on parenting consistency, with large effect size (d=0.9707). One moderate quality Australian RCT (Sanders et al. 2004 +) found both variants of a behavioural family intervention based on the Triple-P Parenting Programme had a significant impact on 2 self-report measures of parenting (no effect sizes reported), although the improvement was not greater in the enhanced version of the programme.
ES8	**ES8. Parenting programmes provided to families at risk of abuse and neglect – impact on child and caregiver/parent wellbeing** Evidence from two RCTs (Dawe and Harnett 2007 +; Sanders et al. 2004 +) provided equivocal evidence about the impact of parenting programmes provided at the early help stage on the wellbeing of children and caregivers/parents. One RCT (Sanders et al. 2004 +) found no evidence of impact on children's behaviour or parental wellbeing as measured by the Depression-Anxiety-Stress Scales and the Parent Problem Checklist. One RCT found some evidence of a decrease in children's scores on the Strengths and Difficulties Scale (p<0.01, no effect size reported) and parental methadone use (p<0.01, no effect size reported), but no reduction in alcohol consumption (Dawe and Harnett 2007 +).
ES9	**ES9. Need for cultural adaptations of parenting programmes provided to families at risk of abuse and neglect** There is a small amount of evidence from 1 good quality US study of parenting programme providers (Self-Brown et al. 2011 +) that family engagement in parenting programmes is critical, ethnicity and language matching is useful but not essential and cultural adaptation of a programme is less important than tailoring it for individual families.
ES10	**ES10. Parent-child interaction therapy provided to families at risk of abuse and neglect – impact on risk of abuse and neglect and quality of parenting**

	Two moderate quality Australian RCTs (Thomas and Zimmer-Gembeck 2011 +, 2012 +) and 1 moderate quality US RCT (Scudder et al. 2014 +) found no impact of parent–child interaction therapy on measures of parental risk of abuse and neglect compared to a comparison group. However, all 3 RCTs found improvements in measures of parenting quality. Thomas and Zimmer-Gembeck (2011 +) found significant differences between intervention and control on maternal sensitivity, with small to medium effect size (d=0.38), as did Thomas and Zimmer-Gembeck (2012 +), also with small to medium effect size (d=-0.47). Scudder et al. (2014 +) found significant improvements in interaction as measured by the Dyadic Parent-Child Interaction coding system in relation to positive attention, with large effect size (d=1.67), negative attention, with large effect size (d=0.83), command sequences, with medium effect size (d=0.54) and praise with large effect size (d=1.02).
ES11	**ES11. Parent-child interaction therapy provided to families at risk of abuse and neglect – impact on child and caregiver/parent wellbeing** Two moderate quality Australian RCTs (Thomas and Zimmer-Gembeck 2011 +, 2012 +) found evidence of impact of parent child interaction therapy on children's wellbeing as measured by the Eyberg Child Behaviour inventory (d=-0.61 Thomas and Zimmer-Gembeck 2011+, d=0.64; Thomas and Zimmer-Gembeck 2012+) and reports of externalising behaviour (d=-0.38 Thomas and Zimmer-Gembeck 2011+, d=0.40; Thomas and Zimmer-Gembeck 2012+). One of the RCTs also found evidence of impact on children's internalising behaviours (d=-0.30 Thomas and Zimmer-Gembeck 2011 +). There was equivocal evidence that parent-child interaction therapy at the early help stage had a positive impact on parents' wellbeing, with 1 study showing a positive impact on parental stress (d=-0.50, Thomas and Zimmer-Gembeck 2011+) and 1 showing no impact (Thomas and Zimmer-Gembeck 2012 +).
ES12	**ES12. Acceptability of parent-child interaction therapy to families at risk of abuse and neglect** One moderate quality US RCT (Scudder et al. 2014 +) found that parents who participated in parent-child interaction therapy had higher satisfaction with services than those in the comparison group, with a moderate effect size (d=0.50).
ES13	**ES13. Multimodal interventions provided to families at risk of abuse and neglect – impact on incidence of abuse and neglect** This evidence statement is based on 1 moderate quality systematic review of reviews (Barlow et al. 2006 +), 1 moderate quality US RCT (Lam et al. 2009 +), 1 poor quality US RCT (DePanfilis et al. 2005 -) and 1 poor quality Portuguese RCT (Pereira et al. 2014 -). Barlow et al. (2006 +) describe multimodal interventions as those comprising a range of components including a mixture of 'family support, preschool education or childcare and community development'. We have used this term to refer to any interventions which combine 2 or more treatment modalities. The evidence was mixed, but suggested that multimodal interventions provided at the early help stage can have a positive impact on incidence of abuse and neglect, with support from the systematic review of reviews (Barlow et al. 2006 +, no effect sizes reported) and 1 moderate quality RCT of an intervention comprising parenting training combined with behavioural couples therapy (Lam et al. 2009 +, r>0.2). However, 1 poor quality RCT (DePanfilis et al. 2005 -) found no evidence of impact on incidence of abuse and neglect, and 1 found an effect in favour of the intervention group of

	medium effect size (partial eta squared =0.13), but only in families with higher levels of parenting stress (Pereira et al. 2014 -).
ES14	**ES14. Multimodal interventions provided to families at risk of abuse and neglect – impact on risk of abuse and neglect and quality of parenting** This evidence statement is based on a systematic review of reviews (Barlow et al. 2006 +) and 3 US RCTs (Carta et al. 2013 +; DePanfilis et al. 2005 -; Lam et al. 2009 +). There was evidence in 1 RCT to suggest that a multimodal intervention combining a parenting intervention with ongoing mobile phone contact was effective in reducing risk of abuse and neglect as measured by parenting stress than a wait list control, with small effect size (d=0.27) (Carta et al. 2013 +). A second RCT (DePanfilis et al. 2005 -) found significant improvements in the higher dosage intervention group compared to lower dosage on in caregiver depressive symptoms (d=0.32), but not for the Difficult Child and Parental Distress subscales of the Parenting Stress Index and measures of everyday stress. Both RCTs found evidence of improved parenting outcomes (d=0.46 and r>0.30 respectively). A systematic review of reviews (Barlow et al. 2006 +) found mixed evidence of effectiveness of parenting programmes in relation to parenting behaviours. Barlow et al. (2006 +) found mixed evidence of effectiveness in relation to parenting behaviours.
ES15	**ES15. Multimodal interventions provided to families at risk of abuse and neglect – impact on child and caregiver/parent wellbeing** Two US RCTs (Carta et al. 2013 +; DePanfilis et al. 2005 -) found mixed evidence of impact on child wellbeing, with significant impacts on some aspects of behaviour such as positive engagement (d=0.43, Carta et al. 2013 +) and internalising behaviour (d=0.34 , DePanfilis et al. 2005 -), but not others, such as externalising behaviour (Carta et al. 2013 +; DePanfilis et al. 2005 -). One RCT (Carta et al. 2013 +) found that parents taking part in a mobile-phone enhanced variant of the Planned Activities Training parenting intervention had significantly better depression scores than a wait list control, with a small to moderate effect size (d=0.31).
ES16	**ES16. Impact of Intensive Family Preservation Services provided to families at risk of abuse and neglect** One moderate quality systematic review of reviews (Barlow et al. 2006 +) reports 1 included review (Dagenais et al. 2004, cited in Barlow et al. 2006 +) which found that targeted Intensive Family Preservation Services had a positive impact on maltreatment (effect size not reported), although not on out-of-home placement, and on child and family functioning (effect size not reported).
ES17	**ES17. Impact of social support programmes provided to families at risk of abuse and neglect** One systematic review of reviews (Barlow et al. 2006 +) reports 1 included review (Clark, 2000 cited in Barlow et al. 2006 +) which found that social support interventions had an impact on abuse and neglect, although this is of low effect size (ES: 0.11). They also had some impact on child development, the home environment and parental knowledge and attitudes, but again these are all of low effect size (ES 0.09, 0.23 and 0.14 respectively). This review is also somewhat dated.
ES18	**ES18. Impact of clinic-based services provided to families at risk of abuse and neglect**

	One moderate quality systematic review (Nelson et al. 2013 +) reports on 1 trial (Dubowitz et al. 2009, cited in Nelson et al. 2013 +) which found a positive impact on child abuse and neglect (no effect sizes reported), and better adherence to medical care and immunisations (no effect sizes reported).
EcES1[19]	**The short, medium, and long-term cost-effectiveness evidence is insufficient to inform UK practice in relation to home visiting interventions** This is based on findings from 3 RCTs, 1 focusing on first time, pregnant women, aged 19 and younger (Barlow et al. 2007 +; DuMont et al. 2011 ++; Robling et al. 2015 +) and on evidence from 1 RCT focusing on mothers with 1 prior substantiated child protective services report (as a non-victim) (DuMont et al., 2011 ++), and mothers with infants less than 3 months old (DuMont et al., 2011 ++). This is also based on evidence from 1 systematic review (Stamuli et al. 2015 ++) focusing on vulnerable pregnant women. The short-term cost-effectiveness evidence from the UK shows mixed effects for different outcomes (Barlow et al 2007 +; Robling et al 2015 +). The medium-to-long-term cost-effectiveness evidence for home visiting programmes in the UK is not clear and further research is needed which includes a longer time horizon. The medium-term cost-effectiveness evidence from the USA indicate that the intervention is cost-effective for child's education outcomes (when measured at the child's seventh birthday) for the whole sample of women with infants younger than 3 months and for a subgroup of mothers with a previous report to child protective services (Dumont et al. 2011, ++). The cost-effectiveness of the intervention does not seem to be clear for both these groups in relation to abuse and neglect, using various outcome measures.
EcES2[20]	The cost-effectiveness evidence is insufficiently comprehensive to inform UK practice in relation to multi-modal interventions for families at risk of abuse and neglect. This is based on evidence from 1 US RCT provided to families of low socioeconomic status with children of all ages (DePanfilis et al. 2008 -, n=154).
EcES3	**EcES3. Cost effectiveness of parenting programmes** The cost-effectiveness evidence is insufficiently comprehensive to inform UK practice in relation to parenting programmes for families at risk of abuse and neglect. This is based on the findings of 1 Australian RCT and economic evaluation based on a decision model provided to parents on methadone maintenance (Dalziel et al 2015 +, n=64).

[19] Previously referred to as ES19
[20] Previously referred to as ES20.

Expert witness testimony

The need for expert testimony

We found no eligible studies relating to early help for children and young people at risk of child sexual abuse (including exploitation) (question 10), female genital mutilation (question 11), forced marriage (question 12) or child trafficking (question 13). In fact, there was a paucity of evidence relating to these forms of abuse across all question areas. We therefore invited testimony from experts in child sexual exploitation, female genital mutilation, forced marriage and child trafficking.

Testimony

The full testimony from the expert witnesses can be found in Appendix D. A brief summary of their testimony is given below.

For child sexual exploitation, the expert witness highlighted poor recognition of the issue by professionals and a lack of early help and prevention due to high thresholds for support. The expert witness highlighted that assessment tools were available but had not been evaluated. Effective response was conceptualised as requiring good multi-agency working and information-sharing.

For female genital mutilation, the expert witness presented a number of risk factors and indicators and referred to the current statutory risk assessment tool (this has not been evaluated). The expert witness highlighted that there can be a lack of professional confidence in asking questions of girls and young women who they think may be at risk. The expert witness stated that psychotherapeutic interventions can be beneficial in ameliorated psychological harm following female genital mutilation, but noted this is often not widely available.

The expert witness on forced marriage also highlighted a lack of professional understanding of this issue, and a tendency in practice not to use a child protection framework to deal with this issue. It was noted that working and sharing information with the whole family may not be appropriate in cases of forced marriage, meaning that clear discussions regarding confidentiality are vital to avoid placing the young person at risk of harm. The expert witness noted that forced marriage is a criminal offence, but that few professionals are aware of this.

The expert witness on child trafficking noted that trafficking can take a range of forms, with some young people experiencing different forms over time. A tool to assist recognition was cited, but the expert witness noted that this has not been evaluated. Information was provided regarding a trial of independent child trafficking advocates, which aimed to improve 'visibility' of trafficked children and continuity of services, and help them to navigate the various systems with which they may be involved. The expert witness noted that the outcomes of the trial were somewhat inconclusive, and an extension of the trial has been agreed by government.

Included studies for these review questions

For references used in economic modelling see Appendix C.

Barlow J, Davis H, McIntosh E et al. (2007) Role of home visiting in improving parenting and health in families at risk of abuse and neglect: results of a multicentre randomised controlled trial and economic evaluation. Archives of Disease in Childhood 92: 229–33

Barlow J, Simkiss D, Stewart-Brown S (2006) Interventions to prevent or ameliorate child physical abuse and neglect: findings from a systematic review of reviews. Journal of Children's Services 11: 6-28

Carta JJ, Lefever JB, Bigelow K et al. (2013) Randomized trial of a cellular phone-enhanced home visitation parenting intervention. Pediatrics 132 (Suppl. 2): S167-73

Dalziel K, Dawe S, Harnett PH et al. (2015) Cost-effectiveness analysis of the Parents under Pressure programme for methadone-maintained parents. Child Abuse Review 24: 317-31

Dawe S and Harnett P (2007) Reducing potential for child abuse among methadone-maintained parents: results from a randomized con-trolled trial. Journal of Substance Abuse Treatment 32: 381-90

DePanfilis D and Dubowitz H (2005) Family connections: a program for preventing child neglect. Child Maltreatment 10: 108-23

DePanfilis D, Dubowitz H, Kunz J (2008) Assessing the cost-effectiveness of Family Connections. Child Abuse and Neglect 32: 335-51

Dishion T, Mun Chung J, Drake EC et al. (2015) A transactional approach to preventing early childhood neglect: The Family Check-Up as a public health strategy. Development and psychopathology 27: 1647-60

DuMont K, Kirkland K, Mitchell-Herzfeld S et al. (2011) Randomized trial of Healthy Families New York (HFNY): does home visiting prevent child maltreatment? New York: New York State Office of Children and Family Services

Green BL, Tarte JM, Harrison PM et al. (2014) Results from a randomized trial of the Healthy Families Oregon accredited state-wide program: early program impacts on parenting. Children and Youth Services Review 44: 288-98

Guterman NB, Tabone JK, Bryan GM et al. (2013) Examining the effectiveness of home-based parent aide services to reduce risk for physical child abuse and neglect: six-month findings from a randomized clinical trial. Child Abuse and Neglect 37: 566-77

Lam WKK, Fals-Stewart W, Kelley ML (2009) Parent training with behavioral couples therapy for fathers' alcohol abuse: effects on substance use, parental relationship, parenting, and CPS involvement. Child Maltreatment 14: 243-54

LeCroy CW and Krysik J (2011) Randomized trial of the healthy families Arizona home visiting program. Children and Youth Services Review 33: 1761-6

Mejdoubi J, van den Heijkant SCCM, van Leerdam FJM et al. (2015) The effect of VoorZorg, the Dutch nurse-family partnership, on child maltreatment and development: a randomized controlled trial. PloS one 10: e0120182

Nelson HD, Selph F, Bougatsos C et al. (2013) Behavioral interventions and counseling to prevent child abuse and neglect: systematic review to update the U.S. Preventive Services Task Force Recommendation. Rockville: Agency for Healthcare Research and Quality

Peacock S, Konrad S, Watson E et al. (2013) Effectiveness of home visiting programs on child outcomes: a systematic review. BMC Public Health 13: 17

Pereira M, Negrão M, Soares I et al. (2015) Decreasing harsh discipline in mothers at risk for maltreatment: a randomized control trial. Infant Mental Health Journal 35: 604-13

Robling M, Bekkers M-J, Bell K et al. (2015) Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial. Lancet: 1-10

Sanders MR, Pidgeon AM, Gravestock F et al. (2004) Does parental attributional retraining and anger management enhance the effects of the Triple P-Positive Parenting Program with parents at risk of child maltreatment? Behavior Therapy 35: 513-35

Scudder AT, McNeil CB, Chengappa K et al. (2014) Evaluation of an existing parenting class within a women's state correctional facility and a parenting class modelled from parent–child interaction therapy. Children and Youth Services Review 47: 238-47

Silovsky JF, Bard D, Chaffin M et al. (2011) Prevention of child maltreatment in high-risk rural families: a randomized clinical trial with child welfare outcomes. Children and Youth Services Review 33: 1435-44

Stamuli E, Richardson G, Duffy S, Robling M, Hood K (2015) Systematic review of the economic evidence on home visitation programmes for vulnerable pregnant women. British Medical Bulletin 115: 19-44

Stover C (2015) Fathers for Change for Substance Use and Intimate Partner Violence: initial community pilot. Family Process 54: 600-9

Thomas R and Zimmer-Gembeck MJ (2011) Accumulating evidence for parent-child interaction therapy in the prevention of child maltreatment. Child Development 82: 177-92

Thomas R and Zimmer-Gembeck MJ (2012) Parent-child interaction therapy: an evidence-based treatment for child maltreatment. Child Maltreatment 17: 253-66

Zielinski DS, Eckenrode J, Olds DL (2009) Nurse home visitation and the prevention of child maltreatment: Impact on the timing of official reports. Development and Psychopathology 21: 441-53

3.7 Early help – aspects of professional practice that support and hinder

Introduction to the review question

The purpose of this question was to ascertain what aspects of professional practice support and hinder early help of children and young people identified as at risk of child abuse and neglect. 'Aspects of professional practice' were defined as including issues such as case management; communication and engagement with children, young people and families; building trust with families; and co-working across disciplines. This question sought to explore professional practices which do not fit easily within the concept of 'an intervention'. This review question, focusing on 'aspects of professional practice and ways of working', was based on the assumption that not all work concerning families at risk of abuse and neglect is easily conceptualised as discrete 'interventions' with clearly identifiable elements and outcomes. These interventions are often identified with manualised models or programmes, which form a part, but certainly not the whole, of work with vulnerable children and families.

We therefore aimed to look at the following.

- Components within particular interventions, as a means of considering common 'effective practice elements' which could potentially also be utilised outside of the context of that intervention.
- studies that were not focused on particular discrete interventions. This question was intended to complement questions 9 to 13, which relate to effective interventions, in acknowledgement of the fact that not all professional practice in this area will take the form of easily delineated 'interventions'.

We used the definition of early help in 'Working Together to Safeguard Children' (2013), that is support provided 'as soon as a problem emerges'. In the context of

abuse and neglect, this means when ‘showing early signs of abuse and/or neglect’. This question therefore considered professional practice with children and young people and/or their caregivers and families following identification of risk or need which is higher than in the general population, but not sufficiently high to meet the threshold for statutory services. The question also used relevant data from questions on views and experiences of children, young people, adult survivors of abuse, parents, carers and practitioners (questions 1 and 2).

Of the studies identified for this question, 8 of the 19 studies were rated as poor (-). The remainder were rated moderate (+). The lower quality studies were largely those which had used qualitative research methods, such as semi-structured interviews, to gather data. This was either the principal component of the study (for example, VOYPIC 2014 -) or part of a larger mixed methods study such as an evaluation, (for example, Barnes et al. 2008 -, 2009 -). The reporting of qualitative methods often lacked detail when describing:

- How the samples for the studies were chosen, describing the characteristics of participants in the study, and how these compare to the characteristics of the wider population from which the sample was taken (for example, Barnes et al. 2008 -). The impact of this is that it is difficult to judge whether the people involved in the study may have been biased towards a particular point of view, compared to the wider population from which they were drawn.
- How their analysis (usually a thematic analysis) had been carried out, making it difficult to judge whether the themes reported in the study were valid.

Review questions

14. What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect?

Question 14 also included material relevant to the following questions:

1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process

of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

Summary of the review protocol

The protocol sought to pinpoint studies that would identify what aspects of professional practice and ways of working support and hinder the effective early help of children and young people identified as at risk of child abuse and neglect.

Study designs that were included for this question were process evaluation, ethnographic and observational studies of practice, analyses of Serious Case Review data.

Population

For question 14:

Children and young people (under 18) who are at risk of abuse or neglect and/or their families and caregivers.

Practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and their families and caregivers. For example, social workers, health professionals, those working in education, voluntary sector providers.

For question 1:

Children and young people (under 18) who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families.

Adults over the age of 18 who experienced abuse or neglect as children reporting their childhood experiences.

For question 2:

Practitioners working with children and young people at risk of, experiencing, or who have experienced abuse and neglect, and/or their caregivers and families. For example, social workers, health professionals, those working in education, voluntary sector providers.

Intervention

Early help is defined in 'Working Together to Safeguard Children' (2013) as support provided 'as soon as a problem emerges'. In the context of abuse and neglect, this means when 'showing early signs of abuse and/or neglect'. 'Aspects of professional practice' were defined as including issues such as case management; communication and engagement with children, young people and families; building trust with families; and co-working across disciplines.

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children's own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings
- schools and colleges
- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Acceptability to children, young people and their caregivers and families (including as reported by adult survivors of child abuse and neglect); quality of parenting and parent-child relationships, including quality of attachment; children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM)); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials registries were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and October 2014. Update searching of the bibliographic databases searches took place in April 2016.

Summary from re-run searches

An updated search was carried out in April 2016 to identify any new studies relating to the effectiveness questions (5, 7, 9-13, 15-19) published since the original

searches were conducted for this guideline. This search used the same search terms and databases as the main search.

As we originally conducted a single search for all of the original 21 questions, the search identified a large number (10,833) items which we used as a 'database' within which to search for studies relevant to our questions. This included specific searches for interventions for which evidence had already been reviewed.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs. Outputs were initially screened against an exclusion tool informed by the overall parameters of the scope.

Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific exclusion criteria for those questions. For question 14 these were as follows:

- country (study is not from Europe, Israel, Australia, Canada, USA, New Zealand)
- evidence type (study is not process evaluation, ethnographic and observational studies of practice, analyses of serious case review data or a systematic review of the above).
- population (not children and young people (under 18) who are at risk of abuse or neglect and/or their caregivers and families OR practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and their families and caregivers. For example social workers, health professionals, those working in education, voluntary sector providers)
- topic (study does not have a specific focus on exploring aspects of professional practice or ways of working in relation to early help OR be an impact study identified in Q9-13.

For questions 1 and 2 these were as follows:

- country (study is not from the UK)

- evidence (not an empirical study including qualitative studies, qualitative components of effectiveness and mixed methods studies, survey studies or systematic reviews of these study types)

- population (population is not children and young people who are at risk of, are experiencing, or have experienced abuse or neglect; their caregivers and families; adult survivors of abuse or neglect; practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families)

- topic (study does not relate to the process of recognising abuse and/or neglect, the process of assessment, services providing early help, services providing intervention following abuse or neglect).

Screening on title and abstract identified 119 papers of potential relevance to this question. After full text screening we identified 19 papers which had specific relevance to aspects of professional practice and ways of working in relation to early help. This included 6 views and experiences papers already presented alongside the effectiveness studies reviewed for question 9. See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence

The following themes were identified on the basis of analysis of all identified papers. Although the aim of this question was to identify common elements of practice across interventions and practice, where all the evidence has come from type of intervention (for example, home visiting) this is reflected in the wording of the evidence statement.

1. Building effective relationships with children and families

The formation of effective working relationships with families was identified in a number of studies as an aspect of professional practice that supported provision of early help for families where risk of abuse and neglect has been identified. This was identified in 8 of the 11 papers relating to home visiting practice (Allen 2007 +; Ayerle et al. 2012 -; Barnes et al. 2008 -, 2009 -; Domian et al. 2010+; Easton et al. 2013 -; Krysik et al. 2008 +; Martin et al. 2011 -) as well as a study on factors assisting

engagement in parenting programmes (Self-Brown et al. 2011 +) and a study relating to GPs' responses to maltreatment-related concerns (Woodman et al. 2013 +).

There were 2 correlational studies which explored the relationship between the quality of the practitioner–family relationship and families' completion of the programme. One study of factors predicting programme completion of a multi-component intervention (Girvin et al. 2007 +) conducted in the USA found that a good interpersonal relationship with workers, as measured by the Helping Relationship Inventory (client interpersonal component) was predictive of programme completion. However, a second correlational study by Brand and Jungmann (2014 +), conducted in Germany, found that there was no statistically significant association between the quality of the helping relationship and drop-out from a home visiting programme, although the relationship was approaching statistical significance (p=0.70).

The importance of relationships was also identified in qualitative studies involving service users, largely mothers within these studies, particularly in relation to home visitors. The qualities that service users appreciated included:

- someone perceived as a friend (Ayerle et al. 2012 -; Martin et al. 2011 -)
- someone who would take time to go through information (Barnes et al. 2008 -)
- someone who listened and showed consideration (Allen 2007 +).

Similarly, practitioners also identified a good relationship as an important foundation for provision of early help. In a small-scale UK qualitative study of GPs (Woodman et al. 2013 +), the authors identified that forming a relationship with families based on trust was vital in enabling them to take necessary actions in relation to addressing maltreatment concerns. Similarly, the larger sample of practitioners (from a range of disciplines) included in Easton et al. (2013 -) identified forming relationships as a key skill, and also an important task within the delivery of effective early help. In relation to parenting programmes, Self-Brown et al. (2011 +) reported that it was important for providers to engage with families and develop a trusting relationship before commencing the programme. LeCroy and Whitaker's (2005) US study of difficult situations encountered by home visitors outlines some of the barriers to building relationships and working effectively with families, including challenges in addressing

family and parenting difficulties, and knowing how to intervene. The authors conclude that this demonstrates that home visitors require adequate training and support in order to discharge this role.

Care-experienced young people involved in a study about effective responses to risk of child sexual exploitation (VOYPIC 2014 -) identified their difficulties in forming relationships with staff, due to high turnover and a perceived lack of confidentiality, as a barrier to disclosing information about potential sexual exploitation.

2. Service approaches

Value base

The ethos or value base of services was a theme identified in several studies. This overlaps with the theme of relationships, but has been presented separately here as this was an issue identified both in relation to individual workers, and to the programme as a whole. Firstly, a number of studies found that service users appreciated approaches which they perceived to be non-judgemental. For example, both parents and practitioners in a poor quality qualitative UK study of effective responses to neglect (Easton et al. 2013 -) identified the 'non-judgemental' nature of services as an important factor in their success. In a UK evaluation of the Family Nurse Partnership (Barnes et al. 2008 -) parents also appreciated the non-judgemental approach of the programme. A similar theme was raised in an Australian study of parents accessing Family Centres (Fernandez 2004 -), a US qualitative study of parents participating in a home visiting programme (Krysik et al. 2008 +) and a study of practitioners and parents participating in the Every Child Succeeds home visiting programme (Stevens et al. 2008 +), who emphasised the importance of non-judgemental support.

One study found that service users valued professional practice which identified and built on their strengths, as well as addressing their weaknesses (Barnes et al. 2008 -).

Understanding individual family circumstances, needs and priorities, and aligning activities to meet these

Service users and practitioners also highlighted the importance of services taking time to understand families' specific needs and priorities, and relating the

intervention to these needs. This was found in relation to support provided by Family Centres (Fernandez 2004 -), in which it was reported that families valued services which addressed their 'individual needs' (p101). Martin et al. (2011 -), in their qualitative research with families to support a process evaluation of the implementation of the Family Nurse Partnership in Edinburgh, describe this as a process of 'agenda matching' between the client and family nurse.

Being able to align services with family needs and priorities was linked to taking time to form an understanding of the current circumstances of the family. Barnes et al.'s (2008 -) qualitative research with service users of the Family Nurse Partnership in England identified that 'spending time exploring clients' lives with them' (p99) was an important element of best practice.

In Domian et al.'s (2010 +) study of coaches providing parenting programmes, the coaches identified that being able to relate materials to a mother's specific situation was important in facilitating engagement, stating: "… just being able to relate to their situation and "basically how they're feeling that day" increased the mother's involvement with program materials" (p404).

Focus on parenting issues

There was also a small amount of evidence that services which focused on parenting (rather than, for example, helping parents to plan for future careers or on their own relationships with others) were valued more highly by service users. For example, 1 moderate quality correlational study of a German home visiting intervention (Brand and Jungmann 2014 +) found that there was a significant association between the proportion of content of home visits that was related to parenting and lower rates of drop-out from the service. Qualitative research with service users of the US Help Me Grow home visiting programme also reported that they valued the home visitors' help in answering their parenting questions (Allen 2007 +). These findings parallel the conclusions of a UK process evaluation of the Family Nurse Partnership (Barnes et al. 2008 -), which found that family nurses reported that their practice was assisted by using clients' wishes to do the best for their children as the foundation for the approach.

Service components

There were also some aspects of practice which were valued, across a range of different types of model aimed at families. Five studies gathering the views of clients found support for provision of practical help in relation to the English implementation of the Family Nurse Partnership model (Barnes et al. 2008 −), as well as a number of US home visiting models (Krysik et al. 2008 +; Paris et al. 2008 +; Stevens et al. 2008 +) and across a range of UK early help services for neglect (Easton et al. 2013 -). Examples of practical help included:

- assistance with travel (for example, to go shopping or to attend child health related appointments, Krysik et al. 2008 +)
- financial assistance, including to buy food and clothes (Fernandez 2004 -; Paris et al. 2008 +)
- provision of toys, diapers and books (Stevens et al. 2013 -).

Provision of emotional support was also identified in a number of studies of different types of interventions for families as an important aspect of professional practice, including in US home visiting models (Paris et al. 2008 +; Stevens et al. 2008 +), an Australian study of family centres (Fernandez 2004 −) and the UK evaluation of the Family Nurse Partnership (Barnes et al. 2008 -).

3. Involvement of family members other than mother

The majority of the studies included here regarded mothers as the principal caregiver, and most of the interventions described were delivered primarily to mothers. Only 2 studies had specifically considered involvement of partners (primarily fathers – no studies included same-sex partnerships). One correlational study looking at factors predicting drop-out from a German home-based early intervention programme (Brand and Jungmann 2014 +) found that involvement of fathers was not significantly associated with risk of drop-out for the sample as a whole (low-income, first-time mothers) but was a significant factor for women with the highest levels of risk (based on factors including young age, consumption of alcohol, consumption of illegal drugs, history of foster care, history of neglect). Qualitative research with male partners in another study (Barnes et al. 2008 -) found that they had not expected to be involved in the intervention (Family Nurse

Partnership) but were pleased to take part. However, it should be noted that this study did not involve fathers who had not chosen to take part in the intervention.

The same 2 studies considered involvement of grandmothers. The correlational study looking at factors predicting drop-out from a German home-based early intervention programme (Brand and Jungmann 2014 +) found that involvement of grandmothers in the intervention was not associated with early drop-out from the programme overall, but was associated with drop-out before completion of less than 25% of the programme (defined as 'early drop-out'). The UK Family Nurse Partnership study (Barnes et al. 2008 -) found that most grandmothers had taken a relatively 'hands-off' role in relation to the intervention.

None of the studies specifically explored included children in 'family' interventions, although 1 study did suggest that practitioners advocated a 'whole family' approach, considering the needs of both children and families (Easton et al. 2013 -).

4. Working with other professionals

A number of studies discussed interprofessional working in the context of early help provision. Links with other agencies were important both in terms of being able to provide better support to families, but also for monitoring risk and escalating as appropriate. One study noted that strong interagency relationships were appreciated by service users receiving family midwife support in Germany as an 'efficient' way of providing holistic support (Ayerle et al. 2012 -), and service users interviewed as part of 1 US study also appreciated their home visitor's ability to link them into other appropriate agencies (Allen 2007 +).

5. Awareness of risk

The 2 syntheses of serious case review/case management review data included both contained relatively little information specifically in relation to intervention at the early help stage. Awareness of risk was a theme identified in both SCR synthesis reports. One study reported a tendency for practitioners in the cases reviewed to lack awareness of particular risk factors within families. For example, 'in some cases where a parent was known to adult services for issues relating to substance use or mental health issues, there was no consideration at all of the wider family environment or the role of the adult as a parent' (Devaney et al. 2013 +, p47). The

second study reported a lack of awareness among practitioners in the cases reviewed of general risk factors for death and injury in children, including 'loss of control and volatility' (Brandon et al. 2008 +).

Interprofessional communication was also related to risk. A study of GPs' responses to families where maltreatment is a concern (Woodman et al. 2013 +) identified the importance of good working relationships between GPs and health visitors in relation to child protection. The synthesis of case management reviews in Northern Ireland (Devaney et al. 2013 +) also identified a lack of information-sharing at the early intervention stage as a factor in the case management reviews they had examined.

6. Care-experienced young people's views of support to address risk of child sexual exploitation

One poor quality UK study sought the views of 55 care-experienced children and young people in Northern Ireland with regards to child sexual exploitation and effective responses to risk (VOYPIC 2014 -). We rated the study as poor due to lack of clarity regarding sampling techniques, analysis procedures and the context in which data were collected.

The study explored the links between running away found that care-experienced children and young people (with experience of foster care or residential child care). The study reported a difference in responses to risk among foster carers and residential care staff. The authors report that some young people felt that foster carers' responses to 'risky behaviour' was effective. They note that foster carers used boundaries to resolve problems and that calm and continuous discussion was an important feature. In contrast, the study reports that young people said that staff in care homes were too quick to involve the police when they felt that a young person was at risk of child sexual exploitation, which they identified as a consequence of staff who lacked confidence and needed further training on these issues. Participants also viewed negatively the use of 'sanctions', such as limiting pocket money or curfews placed on all young people living in a children's home. The study also found that young people felt that providing social activities and encouraging young people to volunteer was an appropriate means of minimising risk.

One young person said: ‘Getting young people involved in the local community and in volunteering … with VOYPIC, youth club … if you have too much time on your hands, you can end up hanging out with the wrong crowd’ (p33).

They also suggested that staff who were able to spend more time with them could help in the same way.

Economics

No economic analysis or modelling was undertaken for this review question.

Evidence statements

ES19	**ES19. Developing effective relationships in provision of support to children and families at risk of abuse and neglect** There is equivocal evidence from 2 moderate quality correlational studies, 1 from the USA (Girvin et al. 2007 +) and 1 from Germany (Brand and Jungmann 2014 +) that relationships between providers and families have an impact on programme completion. There is a good amount of evidence from 11 qualitative studies of mixed quality that the development of a good working relationship is valued by service users and practitioners. This was found in 7 qualitative studies of the views of service users, 2 from the USA (Allen 2007 +; Krysik et al. 2008+), 3 from the UK (Barnes et al. 2008 -; Barnes et al. 2009 -; Martin et al. 2011 -) and 1 from Germany (Ayerle et al. 2012 -), 1 UK study of care-experienced young people at risk of sexual exploitation (VOYPIC 2014 -) and 4 qualitative studies of the views of practitioners, 2 from the USA (Domian et al. 2008 -; Self-Brown et al. 2008 +) and 2 from the UK (Easton et al. 2013 -; Woodman et al. 2013 +). Key elements of an effective relationship from the service user’s perspective include someone perceived as a friend (Ayerle et al. 2012-; Martin et al. 2011 -), taking time to go through information (Barnes et al. 2008 -), listening and showing consideration (Allen 2007 +). From the practitioners’ perspective, developing trust is seen as an important foundation for intervention (Easton et al. 2013 -; Self-Brown et al. 2008 +; Woodman et al. 2013 +).
ES20	**ES20. Non-judgemental approach to home visiting interventions delivered to families at risk of abuse and neglect** There is some evidence from 5 qualitative studies: 2 moderate quality US studies (Krysik et al. 2008 +; Stevens et al. 2008 +), 2 poor quality UK studies (Barnes et al. 2008 -; Easton et al. 2013 -) and 1 poor quality Australian study (Fernandez 2004 -) that service users value services which they perceive to be non-judgemental, and which build on their strengths.
ES21	**ES21. Understanding individual family circumstances, needs and priorities, and aligning activities accordingly** There is some evidence from 3 poor quality qualitative studies, 1 from Australia (Fernandez 2004 -) and 2 from the UK (Barnes et al. 2008 -; Martin et al. 2011 -) that service users value services in which time is taken to understand their individual needs and circumstances, and that this informs the way the intervention is delivered. One good quality qualitative

	US study with parenting programme practitioners (Domian et al. 2008 +) also identified that being able to relate materials to parents' specific situations was an important factor in facilitating engagement.
ES22	**ES22. Focusing on parenting issues in home visiting intervention provided to families at risk of abuse and neglect** There is a small amount of evidence from 2 moderate quality studies, 1 correlational study from Germany (Brand and Jungmann 2014 +) and 1 qualitative study from the USA (Allen 2007 +) that a focus on parenting issues in home visiting interventions delivered to families identified as at risk of abuse and neglect is associated with parental satisfaction with services, as measured by attrition rates and through qualitative interviews. However, it should be noted that the differing designs of these 2 studies makes it difficult to draw strong conclusions.
ES23	**ES23. Provision of practical help to families at risk of abuse and neglect** There is a good amount of evidence of mixed quality from 6 qualitative studies of service users' views: 2 UK studies, 1 of moderate quality and 1 of poor quality (Barnes et al. 2008 +; Easton et al. 2013 -), from 3 moderate quality US studies gathering service user views (Krysik et al. 2008 +; Paris et al. 2008 +; Stevens et al. 2008 +) and 1 poor quality Australian study (Fernandez 2004 -) to suggest that service users value practical help such as provision of material items such as food, toys, clothes and books and assistance with shopping and attending appointments.
ES24	**ES24. Provision of emotional support to families at risk of abuse and neglect** There is some evidence from 2 moderate quality US qualitative studies of service users views (Paris et al. 2008 +; Stevens et al. 2008 +), 1 poor quality Australian study (Fernandez 2004 -), and 2 poor quality UK studies (Barnes et al. 2008 -; Easton et al. 2008 -) that service users value the provision of emotional support as part of early help..
ES25	**ES25. Involvement of wider family in home visiting interventions for families at risk of abuse and neglect** There is a small amount of evidence from 1 moderate quality German correlational study (Brand and Jungmann 2014 +) that involving fathers is associated with mothers at the highest levels of risk being less likely to drop out of home visiting interventions (Brand and Jungmann 2014 +). There is evidence from 1 poor quality UK qualitative study that fathers value being involved (Barnes et al. 2008 -), although this latter finding should be interpreted with caution as study quality was low, and the sample of fathers interviewed was small. There is evidence from 1 moderate quality German correlational study (Brand and Jungmann 2014 +) that the level of involvement of the grandmother in home visiting interventions is associated with lower risk of early drop-out from the intervention, although not with risk of drop-out overall.
ES26	**ES26. Interprofessional working at the early help stage to access support and share information** There is a small amount of evidence from 2 moderate quality qualitative studies, 1 German (Ayerle et al. 2012 -/+)) and 1 from the USA (Allen 2007 +) that service users value the connections practitioners have with other agencies in terms of being able to link them up with other appropriate support and services.
ES27	**ES27. Awareness of risk at the early help stage**

	There is a small amount of moderate quality evidence from 2 syntheses of UK serious case review/case management review data (Brandon et al. 2008 +; Devaney et al. 2013 +) that practitioners working at the early help stage are not always alert to the possibility of escalation of risk in families, including recognition of risk factors or awareness of common causes of child death and injury. There is evidence from 2 moderate quality UK qualitative studies that information-sharing is important for monitoring levels of risk in families, and escalating responses as appropriate (Devaney et al. 2013 +; Woodman et al. 2013 +).
ES28	**ES28. care-experienced young people's views of support to address risk of child sexual exploitation** There is evidence from 1 poor quality UK study of care-experienced young people's views of effective responses to risk of sexual exploitation (VOYPIC 2014 -) that young people thought that care home staff were too quick to involve the police in response to risk of child sexual exploitation, and that use of discussion and boundaries as used by foster carers was a more effective approach. Young people suggested that providing social activities within children's homes to prevent 'absconding' and encouraging young people to volunteer were possible ways of minimising risk. These results should be interpreted with caution, as the study lacked detail in terms of sampling procedures and how the data were analysed.

Included studies for these review questions

Allen SF (2007) Parents' perceptions of intervention practices in home visiting programs. Infants and Young Children 20: 266-81

Ayerle GM, Makowsky K, Schücking BA (2012) Key role in the prevention of child neglect and abuse in Germany: continuous care by qualified family midwives. Midwifery 28: e529-e537

Barnes J, Ball M, Meadows P et al. (2008) Nurse-Family Partnership Programme: first year pilot sites implementation in England, pregnancy and the post-partum period. London: Birkbeck, University of London

Barnes J, Ball M, Meadows P et al. (2009) Nurse-Family Partnership Programme: second year pilot sites implementation in England, the infancy period. London: Birkbeck, University of London

Brand T and Jungmann T (2014) Participant characteristics and process variables predict attrition from a home-based early intervention program. Early Childhood Research Quarterly 29: 155-67

Brandon M, Belderson P, Warren C et al. (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005. London: Department of Education

Devaney J, Bunting L, Hayes D et al. (2013) Translating learning into action: an overview of learning arising from case management reviews in Northern Ireland 2003-2008. Belfast: Queen's University Belfast

Domian EW, Baggett KM, Carta JJ et al. (2010) Factors influencing mothers' abilities to engage in a comprehensive parenting intervention program. Public Health Nursing 27: 399-407

Easton C, Lamont L, Smith R et al. (2013) 'We should have been helped from day one': a unique perspective from children, families and practitioners. Slough: National Foundation for Educational Research

Fernandez E (2004) Effective interventions to promote child and family wellness: a study of outcomes of intervention through children's family centres. Child and Family Social Work 9: 91-104

Girvin H, DePanfilis D, Daining C (2007) Predicting program completion among families enrolled in a child neglect preventive intervention. Research on Social Work Practice 17: 674-85

Krysik J, LeCroy CW, Ashford JB (2008) Participants' perceptions of healthy families: a home visitation program to prevent child abuse and neglect. Children and Youth Services Review 30: 45-61

LeCroy CW and Whitaker K (2005) Improving the quality of home visitation: an exploratory study of difficult situations. Child Abuse and Neglect 29: 1003-13

Martin C, Marryat L, Miller M et al. (2011) The evaluation of the Family Nurse Partnership Programme in Scotland: phase 1 report – intake and early pregnancy. Edinburgh: Scottish Government

Paris R (2008) 'For the dream of being here, one sacrifices ...': voices of immigrant mothers in a home visiting program. American Journal of Orthopsychiatry 78: 141-51

Self-Brown S, Frederick K, Binder S (2011) Examining the need for cultural adaptations to an evidence-based parent training program targeting the prevention of child maltreatment. Children and Youth Services Review 33: 1166-72

Stevens J, Ammerman RT, Putnam FW (2005) Facilitators and barriers to engagement in home visitation: A qualitative analysis of maternal, provider, and supervisor data. Journal of Aggression, Maltreatment and Trauma 11: 75-93

Voice of Young People in Care (2014) Independent inquiry on child sexual exploitation in Northern Ireland: consultation with care-experienced young people. Belfast: Voice of Young People in Care

Woodman J, Gilbert R, Allister J, et al. (2013) Responses to concerns about child maltreatment: a qualitative study of GPs in England. BMJ Open 3: e003894

3.8 Responding to abuse and neglect – effective interventions for children, young people, parents and carers who are experiencing, or have experienced, abuse and neglect

Introduction to the review questions

The purpose of these review questions was to assess the effectiveness of interventions aiming to prevent the recurrence of, or impairment resulting from, abuse and neglect. We devised 5 questions, aiming to assess the effectiveness of interventions following a range of forms of abuse. However, we found no eligible studies of interventions following female genital mutilation (question 17), forced marriage (question 18) or child trafficking (question 19). We therefore invited expert witnesses to provide testimony on each of these topics.

The evidence reviewed for this question comprised of RCTs (and systematic reviews of RCTs).

For question 15, we identified 2 moderate quality systematic reviews, 13 moderate quality RCTs and 8 poor quality RCTs. Many of the studies examined a wide range of outcomes, often measured using multiple scales, some of which were ‘batteries’ of

tests with numerous subscales. Many studies conducted multiple statistical tests across all outcome measures increases the likelihood of 'type 1' errors (false positives), and few studies corrected for this. Due to the heterogeneity in outcome measures, this evidence was not considered suitable for meta-analysis.

For question 16 we found 2 good quality systematic reviews and 1 moderate quality systematic review. A further poor quality systematic review was included, as the results were combined with the better quality systematic reviews. We also identified 1 good quality, 1 moderate quality and 2 poor quality RCTs.

Three economic models were created to explore the cost-effectiveness of:

- a parenting intervention aimed at foster carers (based on evaluation of the KEEP intervention)
- a home visiting and parenting intervention aimed at maltreating parents and their biological children (based on SafeCare)
- cognitive behavioural therapy for children who have been sexually abused.

Review questions

15. What is the impact of social and psychological interventions responding to child abuse and neglect? (Prevention of recurrence, prevention of impairment)

16. What is the impact of social and psychological interventions responding to child sexual abuse? (Prevention of recurrence, prevention of impairment)

17. What is the impact of social and psychological interventions responding to female genital mutilation? (Prevention of impairment)

18. What is the impact of social and psychological interventions responding to forced marriage? (Prevention of impairment)

19. What is the impact of social and psychological interventions responding to child trafficking? (Prevention of recurrence, prevention of impairment)

Summary of the review protocol

The protocol sought to identify studies of the effectiveness of interventions aiming to prevent the recurrence of, or impairment resulting from, abuse and neglect,

examining which interventions are effective, and which are ineffective and identify whether there are any harmful interventions, and assess the cost-effectiveness of interventions.

The study designs originally included for these questions were randomised or quasi-RCTs; impact evaluation (for example, prospective comparative evaluation); economic evaluation; case control studies and systematic reviews of these studies.

Full protocols can be found in Appendix A.

Population

Children and young people (under 18) who are experiencing, or have experienced abuse or neglect and/or their caregivers and families.

Intervention

Social and psychological interventions aiming to prevent recurrence of, or impairment (secondary and tertiary prevention) following:

- abuse and neglect (question 15)
- child sexual abuse (including child sexual exploitation, question 16)
- female genital mutilation (question 16)
- forced marriage (question 17)
- child trafficking (question 18).

Clinical treatment and interventions (for example, treatment for injuries resulting from physical abuse) were excluded.

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children’s own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings
- schools and colleges

- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Acceptability to children, young people and their caregivers and families (including as reported by adult survivors of child abuse and neglect); incidence of abuse and neglect; quality of parenting and parent–child relationships, including quality of attachment, children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials registries were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and October 2014. Update searching of the bibliographic databases searches took place in April 2016.

Summary from re-run searches

An updated search was carried out in April 2016 to identify any new studies relating to the effectiveness questions (5, 7, 9-13, 15-19) published since the original searches were conducted for this guideline. This search used the same search terms and databases as the main search.

As we originally conducted a single search for all of the original 21 questions, the search identified a large number (10,833) items which we used as a 'database' within which to search for studies relevant to our questions. This included specific searches for interventions for which evidence had already been reviewed.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs. Outputs were initially screened against an exclusion tool informed by the overall parameters of the scope.

Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific exclusion criteria for those questions. For questions 15 to 19 these were as follows:

- country (study is not from Europe, Israel, Australia, Canada, USA, New Zealand)

- evidence (randomised or quasi-RCTs; impact evaluation, for example, prospective comparative evaluation); economic evaluation; case control studies and systematic reviews of these studies
- population (not children and young people (under 18) who are experiencing or have experienced abuse or neglect, or their parents and carers)
- intervention (not an intervention aiming to prevent recurrence of, or prevent or ameliorate impairment following abuse and neglect (secondary and tertiary prevention)
- outcome (does not any of the following: acceptability to children, young people and their caregivers and families; incidence of abuse and neglect); quality of parenting and parent-child relationships, including quality of attachment, children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

Papers were then assigned to question 15 or 16 depending on whether the study population had predominantly experienced sexual abuse (question 16) or other forms of abuse (question 15).

For question 15, we identified 175 papers from the initial review of search outputs. Due to the high volume of evidence identified, a decision was taken to focus solely on systematic reviews of reviews, systematic reviews and RCTs and quasi-RCTs (n=111). The full text of these 111 studies were screened according to the review protocol. This identified 15 studies reported across 16 research papers, comprising 2 systematic reviews and 13 RCTs. One of these (Rushton et al. 2010 -) was also reviewed from a cost-effectiveness perspective.

After an update search of literature from 1 January 2014 to 30 April 2016 we identified a further 67 papers of possible relevance to question 15. Following full text screening, 8 further RCTs were included for this question. One of these (Winokur et al. 2015 +) was also reviewed from an economic perspective.

For question 16 we identified 87 papers from the initial review of search outputs (based on title and abstract). Due to the high volume of evidence identified, a decision was taken to focus solely on systematic reviews, RCTs and quasi-RCTs (n=44). The full texts of these studies were screened according to the review

protocol, and 6 studies were included: 4 systematic reviews and 2 RCTs. An additional cost-effectiveness study (McCrone et al. 2015 -), and an economic decision model (Gospodarevskaya et al. 2012) were also identified and reviewed by the economist. The Gospodarevskaya study was not critically appraised as this was a decision model rather than an empirical study, and so does not have a quality rating. Two studies identified from included systematic reviews were also retrieved and reviewed separately (Danielson et al. 2012 +; Trowell et al. 2002 -), as the systematic review results were not clear.

After an update search of literature from 1 January 2014 to 30 April 2016 we identified a further 67 papers of possible relevance to this question. Following full text screening, 2 further RCTs were included. One of these (Carpenter et al. 2016 +) was also reviewed from an economic perspective.

See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence – question 15

Part A – Interventions for children and young people

1. Child-focused adaptation of the Incredible Years Programme

Description of evidence

We found 1 moderate-quality US RCT examining the effectiveness of a version of the treatment version of Incredible Years Dina Child Training Program compared to care as usual (Linares et al. 2012 +) (see Table 19).

Table 19. Study characteristics – interventions for children and young people

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Linares et al. (2012)	Moderate	94	Foster children between the ages of 5 and 8 who had experienced substantiated neglect	Incredible Years Dina Child Training Program	Usual care

Description of intervention

Intervention is the 'treatment' version of the Incredible Years Training programme. The authors report that they selected 12 out of a possible 18 lessons from the Incredible Years Dina Program for Young Children. The goals of this intervention are not clearly specified but the authors note that they selected the treatment version because it had previously been found to be effective in reducing conduct problems for 4- to 8-year-old children with conduct disorders, attention deficit hyperactivity disorder and oppositional defiant disorder, noting the high prevalence of these types of disorders in foster children (Webster-Stratton et al. 2004).

The selected Incredible Years modules were: 'Understanding and Detecting Feelings', 'Detective Wally Teaches Problem Solving Steps', and 'Tiny Turtle Teaches Anger Management'. The authors report that an additional session ('My Homes, My Families') was developed for this project to promote a sense of 'belongingness' to the foster home.

The intervention was delivered by a team of 3 clinicians (1 from a university and 2 from the agency through which the child was accessing services) with at least a masters' level qualification in psychology or social work.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children's health and wellbeing

Contrary to the authors' expectations, children in the intervention group did not show significantly better outcomes than those in the control group. In fact, children in the control group showed significantly better:

- foster carer reports of physical aggression ($p<.05$, effect size not reported)

- foster carer reports of child self-control (p<.05, effect size not reported).

The study found that there was no significant impact for the intervention on teacher ratings of child physical aggression or self-control (statistical data not presented).

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

Not measured.

2. Resilient peer treatment

Description of evidence

We identified 1 poor-quality US RCT (Fantuzzo et al. 2005 -) which explored the impact of resilient peer treatment on outcomes for socially withdrawn children, around half of whom were confirmed to have experienced maltreatment. This study was included as outcomes for maltreated children have been reported separately. The study was rated as poor due to its use of coding systems and scales with unclear reliability and validity and a very short follow-up (2 weeks) (see Table 20).

Table 20. Study characteristics – Resilient Peer Treatment

Study	Quality rating	n	Population	Intervention	Comparison group
Fantuzzo et al. (2005 -)	Poor	82	Socially withdrawn preschool children, 45% of whom were confirmed to have experienced maltreatment)	Resilient Peer Treatment	Attention control (supervised but not facilitated sessions with a peer of average social competency)

Description of intervention

Resilient Peer Treatment is described as child-focused peer-mediated, classroom-based intervention for socially withdrawn, maltreated pre-school children. The main aim of the intervention is to improve the social competence of withdrawn, maltreated

pre-school children by providing opportunities for regular positive play interactions with peers (play buddies) displaying high levels of social functioning. The study notes that ‘during the preschool years, acquiring the ability to form and maintain effective peer relationships in play is a developmental task of foremost importance. Treatment programs for young children should therefore specifically target play as a relevant and potent therapeutic context’ (Fantuzzo et al. 2005, p320).

Participating children interact in play sessions with play buddies (classmates of the participating child who are assessed as showing high levels of prosocial peer play). The sessions are facilitated by a play supporter (parent volunteer identified by teachers and parents involved in the design of the study as being supportive and nurturing).

Play supporters facilitate sessions by setting up the play corner in the classroom, for example, putting out toys (usually available in Head Start classrooms); preparing the play buddy for the session (that is, discussing specific activities which led to positive interactions); observing the play session and providing supportive comments to participating child and their play buddy regarding their interactions.

The intervention was delivered during 15 sessions over a 2-month period (3 sessions planned per week).

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children’s health and wellbeing

The study measured the impact of the intervention on children’s wellbeing in terms of changes in their play behaviours, both within the ‘play corner’ during the intervention,

and in classroom ‘free play’ after the interaction, and on teacher ratings of prosocial and problem behaviours.

1. Observations of play

This study found a significant effect for the treatment group (in favour of the intervention) on children’s levels of:

- collaborative and solitary play in dyadic play-corner interactions, with large and moderate effect sizes respectively (p<.0001, partial eta-squared = .36,; p<.0001, partial eta-squared =.15)
- collaborative and solitary play in classroom free-play, with medium effect size (p<.0001, partial eta-squared =.19; p<.001, partial eta-squared =.14).

There were no treatment group by maltreatment status interactions for these measures, suggesting that the intervention was equally effective for both maltreated and non-maltreated children.

No effect of treatment was found for levels of associative play or social attention in dyadic play-corner interactions or classroom free-play.

2. Teacher ratings of interactive play (Penn Interactive Play Scale)

Significant effects for treatment group were also found in favour of the experimental condition on the play interaction (p<.001, partial eta-squared =.16), play disruption (p<.05, partial eta-squared =.07), and play disconnection (p<.001, partial eta-squared =.14) subscales, and the Penn Interactive Peer Play Scale overall (p<.001, effect sizes not presented). Again, there were no significant treatment group by maltreatment status interactions, suggesting that the intervention was equally effective for both maltreated and non-maltreated children.

3. Teacher ratings of social skills and problem behaviours

Significant effects of treatment group were found for teacher ratings of self-control (partial eta-squared =.15, p<.05) and interpersonal skills subscales (partial eta-squared =.19, p<.001) of the Social Skills Rating System, and the internalising (partial eta-squared =.14, p<.001) and externalising behaviours (partial eta-squared

=.10, p<.001) on the Problem Behaviours scale of the Social Skills Rating System, and for the scale overall (p<.001, effect sizes not presented). There was no significant treatment x maltreatment status interactions, suggesting that the intervention was equally effective for both maltreated and non-maltreated children. Chi-square analyses showed that significantly greater numbers of children in the control condition had scores in the higher ranges on these measures (internalising: $\chi 2$ (1 =7.9, p<.01; externalising: $\chi 2$ (1)=5.0, p<.05).

There was a significant effect in favour of the treatment group on levels of both internalising behaviour, with medium effect size (p<0.001, partial eta-squared =0.14) and externalising behaviour, with small to medium effect size (p<0.001, partial eta-squared =0.10). There was no significant treatment x maltreatment status interactions, suggesting that the intervention was equally effective for both maltreated and non-maltreated children. Chi-square analyses revealed that significantly more children in the control group were in the higher ranges on problem behaviours than children in the treatment conditions (internalising: p<0.01, no effect size reported; externalising: p<0.05, no effect size reported).

No significant effects for the treatment group were found on levels of verbal assertion using the Social Skills Scale of the Social Skills Rating System (statistical data not reported).

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

Not measured.

3. Revictimisation prevention

Description of evidence

We identified 1 moderate-quality US quasi-experimental study (DePrince et al. 2015 +) which compared the effectiveness of 2 types of interventions aiming to prevent victimisation in adolescent girls (aged 12 to 19) with a history of child neglect or abuse (see Table 21). The study also included a third 'no treatment' comparison group. However, results from this element of the study have not been included as the

no treatment group was not randomly allocated, but was formed of individuals who did not attend sessions.

Table 21. Study characteristics – Revictimisation prevention

Study	Quality rating	n	Population	Intervention	Comparison group
DePrince et al. (2015 +) USA	Moderate	134	Adolescent girls (aged 12 to 19) with a history of child neglect or abuse	Revictimisation prevention based on social learning/feminist theory	Revictimisation prevention based on risk detection and executive function

Description of intervention

Both interventions aimed to prevent girls who have experienced abuse and neglect from experiencing intimate partner violence in their relationships. One programme was based on social learning and feminist theory, using the 'Youth Relationships Manual' (Wolfe et al. 1996) and aimed to educate the young women in relation to power within relationships, and to develop the skills to build healthy relationships and recognise abuse. The intervention comprised 12 weekly intervention group meetings lasting 1.5 hours. The comparison intervention had the same duration, but focused on noticing and responding to 'danger cues' in intimate relationships and planning and initiating actions.

Narrative summary

Impact on incidence of abuse and neglect

There was no significant difference between the interventions in relation to sexual or physical revictimisation. The comparison with a 'no treatment' group is not reported here, as this group was not randomly allocated, but comprised those who had not attended any of the sessions. The study did not report figures for within-group changes in rates of revictimisation.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children's health and wellbeing

Not measured.

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

Not measured.

Part B. Interventions for parents or parents and children/young people

This section considers evidence for programmes which are delivered either to parents only, or to both parents and children. It was not possible to identify conclusively which interventions are delivered to both parents and children together, as this is not always clearly described in the studies. We have therefore grouped parent-only and parent and child intervention.

B1. Attachment based interventions

As noted above, it was generally difficult to categorise interventions in to types. This was because many of the interventions share multiple overlapping theory bases, there are similar components in many of the models, and not all models were well described in the papers.

However, within the interventions for parents or parents and children we did identify a subset of 4 interventions which shared 2 important features:

- a basis in attachment theory
- 'dyadic' sessions in which coaches observed parent-child interactions and gave immediate feedback.

These interventions have therefore been grouped together.

1. Attachment and Biobehavioural Catch-up (ABC)

Description of evidence

This intervention was examined in 3 studies considered in 1 moderate quality systematic review (Goldman Fraser et al. 2013 +), and 1 poor-quality US RCT (Lind et al. 2014 -). This study was assessed as poor quality due to the use of an

unpublished tool for coding the parent-child interactions, meaning that the validity of this measure is unclear. Two of the studies were with biological parents of maltreated children, and 2 were with foster parents of children (see Table 22.

Table 22. Study characteristics – Attachment and Biobehavioural Catch-up (ABC)

Study	Quality rating	n	Population	Intervention	Comparison group
Studies reported in Goldman Fraser et al. 2013 +					
Study 1. Reported in Dozier et al. (2006, 2008, 2009), Lewis-Moriarty et al. (2012) (USA)	Risk of bias as rated by review authors = medium	93	Foster parents and young children in their care (<39.4 months)	ABC	Active control (Developmental Education for Families programme)
Study 2. Reported in Bernard et al. (2012), Dozier et al. unpublished study A, Dozier et al. unpublished study B (USA)	Risk of bias as rated by review authors = medium	120	Parents involved with CPS and their young children (1.7 months to 21.4 months, mean=10.1)	ABC	Active control (Developmental Education for Families programme)
Study 3. Sprang et al. (2009) (USA)	Risk of bias as rated by review authors = medium	58	Foster parents and young children in their care, mean age 42.5 months	ABC	Waiting list
Other trials					
Study 4. Lind et al. (2014 -) (USA)	Poor	260	Children under the age of 2 at referral and their biological parents	ABC	Developmental Education for Families programme

Description of intervention

ABC is a manualised intervention designed to help parents behave in ways which support their child's self-regulation skills in relation to affect, behaviour and physiology. The intervention comprises 10 weekly home visits with caregiver and child together.

Lind et al. (2014 -) note that the intervention is intended to change parenting behaviours to ensure that responses to the child are:

- synchronous (for example, following the child's lead and giving them control, and responding quickly and with sensitivity)
- nurturing (that is, responding sensitively to distress which is hypothesised to enable children to manage negative affect and to develop secure and organised attachments)
- non-frightening.

Provision of the intervention to foster carers' aims to help address problems in the child's self-regulation, and help foster parents 'create an environment that enhances regulatory capabilities' (Dozier et al. 2011, p771).

The intervention in the Lind et al. (2014 -) study is delivered by parent coaches (with some supervision) who had '... strong interpersonal skills and past experience working with children ...' (p1462) and a mixture of bachelor and masters' level education. This study also mentions use of video feedback. This information is not provided for the studies in the systematic review.

Narrative summary

Impact on incidence of abuse and neglect

Not reported for any of the studies.

Impact on risk of abuse and neglect

Risk of abuse and neglect was measured in 1 study: Sprang et al. (2009, cited in Goldman Fraser et al. 2013 +) using self-report on the Child Abuse Potential Inventory (Milner 1986). The intervention was found to have a significant impact with a large effect size (partial eta-squared =0.791). However, it should be noted that this

study was with foster parents – not the parents who had originally maltreated the child.

Impact on quality of parenting and parent-child relationships

Studies with biological parents

This was measured in 1 of the 2 studies with biological parents, and measured impact on attachment behaviours (Bernard et al. 2012, cited in Goldman Fraser et al. 2013 +). This study found a significant impact on attachment behaviours, including:

- significantly decreased proportions of children of maltreating parents with disorganised attachment, as measured by the Strange Situation Procedure (no effect size reported) (Bernard et al. 2012, cited in Goldman Fraser et al. 2013 +)
- significantly increased proportions of children of maltreating parents with secure attachments, as measured by the Strange Situation Procedure (no effect size reported) (Bernard et al. 2012, cited in Goldman Fraser et al. 2013 +).

Studies with foster parents

One of the studies of use of ABC with foster parents examined the impact on attachment behaviours, finding:

- significant reductions in avoidant attachment behaviour in children of foster parents, as measured using a parent attachment diary (no effect size reported) (Dozier et al. 2009, cited in Goldman Fraser et al. 2013 +)
- no significant differences in secure attachment behaviour.

Impact on children's health and wellbeing

Studies with biological parents

Both of the studies providing ABC or attachment-based interventions to biological parents examined impact on children's health and wellbeing.

Two studies measured children's emotional expression using the 'tool task' (Matas et al. 1978), in which parents and children are given joint problem-solving tasks which are coded for negative affect using subscales measuring the child's anger, anger towards parent, global sadness and anger. These are then aggregated into a composite negative affect score. The scoring manual for this task is unpublished,

meaning that the validity of this measure is unclear. Two studies of ABC using this measure found a significant impact on overall negative emotional expressivity, 1 with small to medium effect size (d=0.42, Lind et al. 2014 -) and 1 with no effect size reported (Dozier et al., unpublished study A, cited in Goldman Fraser et al. 2013 +).

Studies with foster parents

Both of the studies with foster parents also measured the impact of ABC on children's wellbeing.

One study of ABC (study 3) using the Child Behaviour Checklist found a significant impact on both internalising behaviour, with large effect size (partial eta squared =0.436) and externalising behaviour, with large effect size (partial eta squared =0.511) (Sprang et al. 2009, cited in Goldman Fraser et al. 2013 +). However, study 1 found no impact of ABC on behavioural problems as measured by parent daily report (Dozier et al. 2006).

Study 1 found significant impact of ABC cortisol levels (Dozier et al. 2006, cited in Goldman Fraser et al. 2013 +). The authors of the review note that 'cortisol is an indicator of neurobiological response to stress and serves as a proxy indicator of regulation and functioning of the hypothalamic-pituitary-adrenal (HPA) axis, itself activated by physical and psychological stressors' (Goldman Fraser et al. 2013, p37). The review reports found that, for this study 'children in the ABC group exhibited more normative cortisol regulation then children in the control condition, although the timing of assessment was not specified and baseline cortisol measures were not reported' (Goldman Fraser et al. 2013, p37). It also found significant impacts on a theory of mind task, and marginally significant impact on cognitive flexibility measured using a card sort task (Lewis-Moriarty et al. in press, cited in Goldman Fraser et al. 2013 +).

Impact on caregiver/parents' health and wellbeing

This was measured in 1 study, which found a significant impact of ABC on foster parents' levels of stress, with large effect size (partial eta-squared =0.59) (Sprang et al. 2009, cited in Goldman Fraser et al. 2013 +).

Impact on service outcomes

Not reported for any of the studies.

2. Child-Parent Psychotherapy (CPP)

Description of evidence

Evidence on child-parent psychotherapy (CPP) was provided in 1 moderate quality systematic review (Goldman Fraser et al. 2013 +), which reviewed 2 US RCTs, both of which were assessed as at medium risk of bias (Cicchetti et al. 2006; Toth et al. 2002, both cited in Goldman Fraser et al. 2013 +). Two moderate-quality US RCTs (Stronach et al. 2006 +; Toth et al. 2015 +) extended 1 of the studies included in the systematic review (Cicchetti et al. 2006, cited in Goldman Fraser et al. 2013 +), looking at outcomes at 12-month follow-up. CPP was also investigated in a moderate-quality US RCT reported in 3 papers (Lieberman et al. 2005, 2006; Ghosh et al. 2011). These report findings immediately post-treatment (Lieberman et al. 2005 +), at 6-month follow-up (Lieberman et al. 2006 +) and considering outcomes for children with differing levels of trauma (Ghosh et al. 2011 +).

Table 23. Study characteristics – Child-Parent Psychotherapy (CPP)

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Studies reported in Goldman Fraser et al. 2013 +					
Study 1. Toth et al. (2002) (USA)	Risk of bias as rated by review authors = medium	87	Children aged 4 years in maltreating families	CPP	Active control Usual care
Study 2. Cicchetti et al. (2006) (USA)	Risk of bias as rated by review authors = medium	137	Infants aged 12 months in maltreating families	CPP	Active control (psychoeducational parenting intervention) Usual care
Other studies					
Study 2a. Stronach et al. (2006) (follow-up of Cicchetti et al. 2006) (USA)	Moderate	137	Infants aged 12 months in maltreating families	CPP	Active control (psychoeducational parenting intervention) Usual care

Study 2b. Toth et al. (2015) (follow-up of Cicchetti et al. 2006) (USA)	Moderate	105[21]	Mothers from the Cicchetti et al. (2006) sample identified for neglect, infants aged 12 months	CPP	Active control (psychoeducational parenting intervention) Usual care
Study 3. Reported in Lieberman et al. (2005, 2006) and Ghosh et al. (2011) (USA)	Moderate	75	Preschool-aged children and their mothers referred to treatment following the child's exposure to domestic violence	CPP	Individual psychotherapy plus case management

Description of intervention

CPP is a relationship-based psychotherapy delivered to both parents and children, with a focus on supporting formation of and repairing the caregiver–child attachment relationship (Goldman Fraser et al. 2013 +). The intervention aims to help mothers understand the impact of the past on their own parenting, and to improve their responsiveness, sensitivity and attunement to the needs of their child (Toth et al. 2015 +).

Stronach et al. (2006 +) report that the therapy provided is 'non-directive' and 'non-didactic' and focuses on the mother's negative perceptions of her relationship with her child stemming from her own negative experiences or insecure representational model. During the sessions the therapist observes interactions between the mother and child (using the child's own toys) and responds 'empathically' to these. Lieberman et al. (2005 +) note that the treatment manual includes clinical strategies and clinical illustrations to address the following domains of functioning: play; sensorimotor disorganisation and disruption of biological rhythms; fearfulness; reckless, self-endangering and accident-prone behaviour; aggression; punitive and

[21] Plus non-maltreating comparison group n=52.

critical parenting; and the relationship with the perpetrator of the violence and/or absent father.

In all included studies, the intervention comprised weekly visits (reported as being 1 hour long in Goldman Fraser et al. 2013 and Lieberman et al. 2005), lasting for 50-52 weeks. In both the Stronach et al. (2006 +) and Lieberman et al. (2005 +) studies, the intervention was delivered by masters' level therapists. This information is not provided in Goldman Fraser et al. (2013 +).

Narrative summary

Impact on incidence of abuse and neglect

Not reported for any of the studies.

Impact on risk of abuse and neglect

Not reported for any of the studies.

Impact on quality of parenting and parent-child relationships

The impact of CPP on quality of parenting was explored in 2 studies – study 1 and study 2/2a (Toth et al. 2002, cited in Goldman Fraser et al. 2013 +; Cicchetti et al. 2006, cited in Goldman Fraser et al. 2013 +, and 12-month follow-up reported in Stronach et al. 2006).

Studies 2 and 2a measured attachment using the Strange Situation Procedure (Ainsworth et al. 1978). The study found:

- Significantly higher rates of secure attachment immediately post-treatment in the intervention group compared to usual care, with large effect size (Cohen's h=1.16 to 1.39, p<0.01) although not compared to a psychoeducational parenting intervention (Cichetti et al. 2006, cited in Goldman Fraser et al. 2013 +), and higher rates of secure attachment at 12-month follow-up compared to usual care, with small effect size (p=.03, ES=0.28) and the psychoeducational parenting intervention group, with small effect size (p=.03, ES=0.25) (Stronach et al. 2006 +).
- Significantly higher rates of becoming securely attached immediately post-treatment in the intervention group compared to usual care, with large effect size

(p<0.01, Cohen's h=1.34) although not compared to the psychoeducational parenting intervention (Cichetti et al. 2006, cited in Goldman Fraser et al. 2013 +)

- Significantly lower rates of disorganised attachment immediately post-treatment in the intervention group compared to usual care (p=0.01, Cohen's h=0.83), although not compared to the psychoeducational parenting intervention (Cichetti et al. 2006, cited in Goldman Fraser et al. 2013 +). This was not sustained at 12-month follow-up (p=.20, ES=0.17) (Stronach et al. 2006 +).

Study 1 (Toth et al. 2002, cited in Goldman Fraser et al. 2013 +), used the MacArthur Story Stem Battery to explore self-representations as a measure of the health of caregiver–child relationships and found:

- significantly greater decline in negative self-representations for CPP families compared to active control or usual care (p<0.01, no effect size reported)
- a trend towards greater increases in positive self representations for CPP families compared to active control (p<0.10, no effect size reported)
- a trend towards a greater decrease in maladaptive maternal representations for CPP famiies compared to usual care (p<0.10, no effect size reported)
- no significant differences between groups in terms of adaptive maternal representations or false self-representation.

Impact on children's health and wellbeing

Child behaviour problems

Study 2a and Study 3 examined the impact on children's wellbeing via maternal reports of child behaviour problems measured using the Child Behaviour Checklist (CBCL). Study 3 found significantly greater improvement for CPP families compared to the comparison group for behavioural problems immediately post-treatment, with small effect size (p<0.05, d=0.24) (Lieberman et al. 2005 +), and at 6 months follow-up, with small to medium effect size (p<0.05 d=0.44) (Lieberman et al. 2006 +). This effect was shown to be greater for children in the intervention group who had experienced 4 or more traumatic and stressful events (TSEs) (Ghosh et al. 2011 +). However, study 2 found no significant impact of the intervention on CBCL scores at 12 month follow-up (p=0.32).

PTSD symptoms

Study 3 investigated post-traumatic stress disorder (PTSD) symptoms. It was found that:

- There was a significantly greater decrease in numbers of PTSD symptoms immediately post-treatment in the CPP group compared to the comparison group, with medium effect size ($p<0.001$, $d=0.63$) (Lieberman et al. 2005 +). This effect was shown to be greater for children in the intervention group who had experienced 4 or more TSEs ($p<0.05$, eta-squared = 0.05) (Ghosh et al. 2011 +).
- There was a significantly lower rate of diagnosis of PTSD amongst the CPP group post-treatment, with medium effect size ($p<0.01$, phi=0.037) (Lieberman et al. 2005 +). This effect was greater for children in the intervention group who had experienced 4 or more TSEs ($p<0.01$, phi=0.55) (Ghosh et al. 2011 +).

Impact on caregiver/parents' health and wellbeing

Studies 2b and 3 also investigated the impact of CPP on caregiver/parents' health and wellbeing, and found mixed impact.

Toth et al. (2015 +) found that, immediately post-intervention, mothers in the CPP condition showed a significantly greater reduction in child-related psychological stress (parental perception of stress related to dealing with child's fluctuating mood, low adaptability and high demanding behaviour; difficulty in behaviour regulation and inability to reinforce parenting role) than mothers who had received standard community services, with large effect size ($d=2.29$). It is unclear whether mothers in the CPP group showed a significantly greater reduction in child-related psychological stress than mothers in the psychoeducational parenting intervention, but a large effect size is reported ($d=1.45$). However, for parent-related psychological stress (concerns about parental efficacy and competence; parental health and social isolation; relationship with others) mothers in the CPP condition did not experience a significant reduction in relation to any of the other groups.

In study 3, there was a statistically significant impact of the intervention, with medium effect size on the avoidance subscale of the clinician-administered PTSD scale ($p<0.05$, $d=0.5$), and a marginally significant impact with small to medium effect size

on scores on the scale as a whole (p<0.1, d=0.41) (Lieberman et al. 2005). This does not appear to have been measured at 6-month follow-up.

Post hoc tests conducted by Ghosh et al. (2011 +) found that mothers in the CPP group showed a significant improvement in PTSD symptoms from pre- to post-test, for mothers of both <4 TSE children (t(21)=3.81, p<0.01, d=0.68) and 4+ children (t(21) =3.17, p<0.01, d=0.92), whereas in the comparison group only mothers of <4 children made a significant improvement (t(17)=2.55, p<0.05, d=0.76). Chi-squared analyses found that, at post-test, in the ITT sample, CPP 4+ mothers were significantly less likely to have a diagnosis of PTSD (X2(1)=7.70, p=.01., phi=.47), with 15% of CPP mothers and 60% of comparison group mothers meeting PTSD criteria. No significant treatment differences for maternal PTSD were found for the <4 group. (Ghosh et al. 2011 +)

There was a marginally significant impact of the intervention, with small to medium effect size for maternal functioning as measured by the Symptoms Checklist-90 Revised (Derogatis 1994) Global Severity Index (p=0.07, d=0.37) (Lieberman et al. 2005 +). It is unclear whether this impact was continued at 6-month follow-up, as results of the intent-to-treat analysis are not clearly reported in Lieberman et al. (2006 +). Impact on this measure was not more pronounced for parents of children with a higher number of TSEs (Ghosh et al. 2011 +).

Impact of the intervention was not significantly better at immediate post-treatment than control group for the re-experiencing and hyperarousal subscales of the CAPS measure (p=ns, d=0.29; p=ns, d=0.19) (Lieberman et al. 2005).

Impact on service outcomes

Not reported for any of the studies.

3. Parent-Child Interaction Therapy

Description of evidence

We found 2 systematic reviews which reviewed evidence in relation to parent–child interaction therapy (PCIT) (Barlow et al. 2006 +, 2 studies; Goldman Fraser et al. 2013 +, 2 studies) (see Table 24). One study was reported in both Barlow et al. and Goldman Fraser et al. (Chaffin 2004) – we largely report the data here as reported in

Goldman Fraser et al. (2013 +), as this provides greater detail. This is with the exception of 2 outcome measures, which are only reported in the Barlow et al. review.

Table 24. Study characteristics – parent-child interaction therapy

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Studies cited in Barlow et al. 2006 +					
*Chaffin (2004) (USA) (also covered Goldman Fraser et al. 2013 +)	Risk of bias related to allocation concealment rated 'unclear' by reviewers	110	Physically abusive parents	PCIT	Standard community-based parenting group
Terao (1999) (country not reported)	Risk of bias related to allocation concealment rated 'unclear' by reviewers	34	Physically abusive families	PCIT	Standard family preservation services
Studies cited in Goldman Fraser et al. 2013 +					
*Chaffin et al. (2004)	Risk of bias as rated by reviewers = medium	110	Physically abused children ages 4 to 12 and their caregivers	PCIT adaptation Package	1. Enhanced PCIT adaptation package 2. Service as usual
Chaffin et al. (2011)	Risk of bias as rated by reviewers = low	153	Neglected or physically abused children ages 2.5 to 12 years and their caregivers.	PCIT adaptation Package	1. Self-motivational orientation plus service as usual parenting programme 2. PCIT plus service as usual orientation 3. Usual care

Description of intervention

The descriptions of PCIT differ slightly across the above studies. Common to all descriptions is a focus on parent-child interactions, and aiming to change 'dysfunctional' patterns of interaction. It is our understanding that 'live' observations of parent-child dyads, with instantaneous feedback, is a key feature of the intervention, although this is not mentioned in relation to Terao (1999 cited in Barlow

et al. 2006 +). However, this may reflect the brevity of description in the systematic review.

The specifics of the intervention in each study were as follows:

- Chaffin (2004) – 6 group-based sessions on increasing parental motivation, followed by clinic-based individual parent-child dyad sessions.
- Terao (1999) – programme delivered over 14 weekly sessions and comprised behaviour management and communication skills training.
- Chaffin et al. (2004, 2011) – a standard PCIT, based on social learning and attachment theory, adapted for abusive or neglectful parents. Six clinic-based parent group sessions/therapeutic sessions, 12 to 14 approximately 1-hour clinic-based individual sessions with parent and child together. This intervention included 3 phases:
  - motivational intervention (orientation phase)
  - child-directed interaction phase during which parents develop child-centered interaction skills
  - parent-directed interaction phase during which effective discipline skills are the focus.

  The intervention uses live parent–child skills rehearsal, with live coaching by the therapist (immediate feedback from therapist from observation room to parent via wireless earphone).

Narrative summary

Impact on incidence of abuse and neglect

Two of the 3 studies examined recurrence of abuse (as measured by reports to the child welfare system) (Chaffin et al. 2004, 2011, cited in Goldman Fraser et al. 2013 +).

One study found that the adapted PCIT package was significantly more effective than usual care in terms of a ‘survival analysis’ of recidivism (p=0.02, effect size not reported) (Chaffin et al. 2004, cited in Goldman Fraser et al. 2013 +). However, this effect was not observed for the ‘enhanced’ PCIT package.

The second study found that the combination of PCIT and a self-motivational intervention resulted in significantly reduced rates of recidivism, compared to service as usual, although p values are not reported (p=NR, hazard ratio = 0.20) (Chaffin et al. 2011, cited in Goldman Fraser et al. 2013 +).

Impact on risk of abuse and neglect

Two studies examined impact of PCIT on risk of abuse and neglect, as measured using the Child Abuse Potential Inventory (Milner 1986). (Chaffin et al. 2004, CAPI data only reported in Barlow et al. 2006 +; Terao 1999 cited in Barlow et al. 2006 +).

One study (Terao 1999, cited in Barlow et al. 2006 +) found a large significant difference in CAPI scores favouring the intervention group, with large effect size (SMD=-0.99, 95% confidence intervals -1.71 to -0.27).

However, 1 study found no impact of PCIT on CAPI scores compared to the comparison group (SMD=0.03, 95% confidence intervals -0.42 to 0.48 , Chaffin et al. 2004, cited in Barlow et al. 2006 +).

Impact on quality of parenting and parent-child relationships

One study measured the impact of PCIT on parenting and parent-child relationships (Chaffin et al. 2004, cited in Barlow et al. 2006 +), with increased rates of positive parenting behaviours favouring the intervention group (SMD=0.50 [95% CI 0.04 to 0.95]) and rates of negative parenting behaviours higher in the control group (SMD=0.75 [95% CI 0.29 to 1.22]) This study also found non-significant impact, but with small to medium effect sizes for parental rigidity (SMD=0.41, 95% confidence interval -0.04 to 0.86) and problems with children (SMD=0.39 95% confidence interval -0.06 to 0.85).

Impact on children's health and wellbeing

One study measured the impact of PCIT on children's health and wellbeing (Chaffin et al. 2004, cited in Barlow et al. 2006 +), and found no difference on measures of externalising problems (SMD=0.06, [95% CI-0.39 to 0.51]) or internalising problems (SMD=-0.02, [95% CI-0.47 to 0.43]).

Impact on service outcomes

Not measured/reported for any studies.

4. Promoting First Relationships

Description of evidence

We found 1 poor-quality US RCT, reported in 2 papers (Spieker et al. 2012 -, 2014 -) evaluating the effectiveness of the Promoting First Relationships (PFR) intervention for caregivers of toddlers with a recent court-ordered placement in foster care, and 1 poor-quality reanalysis of data from the same RCT, looking specifically at outcomes for birth families (Oxford et al. 2013 -) (see Table 25).

Although the studies originate from the same sample, they have been classified as 2 studies, as the second has a different sample population and size. Both studies were rated as poor because of high attrition rates from both studies (32% in Spieker et al. 23% in Oxford et al.) and with no intent to treat analysis. In particular, the exclusion from the Oxford et al. (2013 -) study of dyads that were no longer in the same household (presumably those in which the child had been removed back in to care) was considered a possible source of bias, as these are likely to be families with the highest level of need, for whom the intervention may have been less likely to be effective. Exclusion of these families may therefore have inflated estimates of the effectiveness of the intervention.

Table 25. Study characteristics – Promoting First Relationships

Study	Quality rating	n	Population	Intervention	Comparison group
Study 1. Spieker et al. (2012) Spieker et al. (2014) (USA)	Poor	210	Child–caregiver dyads: caregivers of toddlers with a recent court-ordered placement in foster care. Caregivers could be biological parents (n=56), kinship carers (n=65) or foster carers (n=89)	Promoting First Relationships	Early Education Support
Oxford et al. (2013) (USA)	Poor	56	Child-caregiver dyads: biological parents of toddlers who had experienced a court-ordered change in primary caregiver in the previous 7 weeks and had recently been reunified with their child	Promoting First Relationships	Early Education Support

Description of intervention

Promoting First Relationships is an attachment-based infant mental health intervention. Its use in these studies is predicated on the idea that placement in child welfare can result in disrupted attachments, which in turn can mean that children are less able to use their caregivers to regulate stress, and can be perceived as difficult to calm or soothe (Spieker et al. 2012 -). The authors report that 'in conjunction with video feedback, PFR uses reflective practice principals to focus on the deeper emotional feelings and needs underlying difficulties in the parent and child relationships, and to help caregivers think about their child's developing mind' (Spieker et al. 2012 -, p273).

The intervention comprises 10 weekly sessions around 60-75 minutes in length, and includes the use of 5 videotaped child–caregiver interactions which are used to guide sessions and prompt discussion of the strengths of the parent and their interpretation of the child's behaviour. Providers also practise the 'Promoting First Relationships Ways of Being' which emphasise the importance of establishing an emotional connection with the caregiver, sensitive interviewing techniques, reflective practice, positive and instructive feedback, reflection, and responsive and validating statements. The intervention is delivered by 'masters' prepared' providers working for 1 of 5 community mental health agencies. Providers were trained for a total of 90 hours over 6 months and were mentored during the provision of the intervention to 3 families. Weekly reflective sessions with other providers were also conducted throughout the programme.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

For the study looking at impact across all caregiver groups (that is, birth parents, foster carers and kinship carers, Spieker et al. 2012 -) the study found a significant impact of PFR compared to the comparison group on:

- Caregiver sensitivity with a small to medium effect size at the immediate post-intervention assessment (p=.024, d=0.41) measured using the Nursing Child Assessment Teaching scale, however differences were no longer statistically significant at the 6 months post-intervention assessment, although still of a small effect size (p=.158, d=0.29).
- Caregiver understanding of toddlers with a small to medium effect size at the immediate post-intervention assessment (p=.042, d=0.36) measured using the Raising a Baby scale, however differences were only marginally significant at the 6 months post-intervention assessment (p=.062, d=0.39).
- Monthly rates of change in scores of caregiver sensitivity (p<.01) and a marginally significant effect on scores of caregiver understanding of toddlers (p<.10) between baseline assessments and immediate post-intervention assessments. However, monthly rate of change between immediate post-intervention assessments and 6 months post-intervention assessments and baseline assessments and 6 months post-intervention assessments showed no significant effects for the intervention on either of these measures (statistical data not provided).

This study did not find a significant impact for the intervention at either the immediate post-intervention assessment or the 6 months post-intervention assessment on caregiver support (measured using the indicator of parent–child interaction) (p=.491, d=0.11; p=.446, d=0.18); or caregiver commitment to the child (measured using the This Is My Baby scale (p=.354, d=-0.17; p=.414, d=0.16).

This study did not find a significant impact for the intervention across any time points on monthly rates of change in scores of caregiver support or caregiver commitment.

Spieker et al. (2014 -) additionally explored impact of the intervention on stability and permanency outcomes. Stability was defined as whether the child had remained with the same caregiver since randomisation in to the study. Permanency included reunification and discharge to the study birth parent, adoption by the study kin or non-kin caregiver or legal guardianship by the study caregiver. The study found no overall effect of the intervention on either stability or permanency outcomes. However, there was an effect of intervention among foster/kin caregivers, but not among birth parents. Foster/kin caregivers in the intervention group were more likely

to have stable placements which resulted in permanency compared to those in the comparison group (OR 3.83, 95% CI 1.07 to 13.78).

The Oxford et al. (2013 -) study did not explore caregiver outcomes.

Impact on children's health and wellbeing

Both studies examined the impact of PFR on children's wellbeing.

The study looking at impact across all caregiver groups (that is, birth parents, foster carers and kinship carers, Spieker et al. 2012 -) found a significant impact of PFR compared to the comparison group on child competence with a small to medium effect size at the immediate post-intervention assessment (d=.42, p=.031), measured using the Brief Infant Toddler Social and Emotional Assessment tool, however differences were no longer statistically significant at the 6 months post-intervention assessment (d=-0.16, p=.429).

However, Spieker et al. (2012 -) found no significant impact of PFR on the majority of measures of child wellbeing including:

- child attachment security at either the immediate post-intervention assessment or the 6 months post-intervention assessment on child attachment security measured using the Toddler Attachment Sort-45 (p=.410, d=0.16; p=.736, d=.-0.13)
- child engagement measured using the Indicator of Parent–Child Interaction (p=.386, d=-0.15; p=.402, d=-0.18)
- child problem behaviours measured using the Brief Infant Toddler Social and Emotional Assessment (p=.924, d=-0.02; p=.434, d=-0.16)
- child internalising problems (p=.879, d=0.03), externalising problems (p=.520, d=0.13,), sleep problems (p=.094, d=0.34,) and 'other problems' (p=.475, d=0.14), all measured using subscales of the Child Behavior Checklist for Ages 1.5-5
- emotional regulation (p=.314, d=0.20) and orientation (p=.723, d=0.06), both measured using the Orientation/Engagement factor of the Bayley Behavior Rating scales.

This study also found no significant effects for the intervention in monthly rates of change in scores of child attachment security, child engagement and child behaviour across any time points (statistical data not provided).

This study further found that the intervention performed worse than the comparison group on monthly rates of change in scores of child competence between immediate post-intervention assessments and 6 months post-intervention assessments, however this was not the case between baseline assessments and immediate post-intervention assessments, or baseline assessments and 6 months post-intervention assessments (statistical data not provided).

The Oxford et al. (2013 -) study focused on caregiver reported sleep problems as measured using 4 items from the Child Behaviour Checklist (Achenbach and Rescorla 2000), and 2 items from the Brief Infant Toddler Social and Emotional Assessment (BITSEA, Briggs-Gowan and Carer 2002) and their relationship with separation distress, as measured by the Toddler Attachment Sort-45 (Kirkland et al. 2004). The study found that being in the intervention group (compared to the control group) significantly predicted reduction in sleep problems, with medium to large effect size ($p<0.05$, $d=0.67$). Path analysis showed that the relationship between being in the intervention group and reduced sleep problems was mediated by impact on separation distress.

Impact on caregiver/parents' health and wellbeing

Spieker et al. (2012 -) investigated the impact of PFR on caregiver wellbeing, but found no significant impact on any of the measures including:

- stress related to perceptions of caring for a difficult child at either the immediate post-intervention assessment or the 6 months post-intervention assessment ($p=.216$, $d=-0.22$; $p=.790$, $d=0.06$,) measured using the short form of the Parenting Stress Index
- stress related to perceptions of a dysfunctional caregiver–child relationship at either the immediate post-intervention assessment or the 6 months post-intervention assessment ($p=.478$, $d=-0.13$, $p=.415$, $d=-0.17$,) measured using the short form of the Parenting Stress Index

- monthly rates of change in scores of caregiver stress related to perceptions of caring for a difficult child, or caregiver stress related to perceptions of a dysfunctional caregiver–child relationship across any time points (statistical data not provided).

Impact on service outcomes

Not measured.

B2 Other interventions

The remainder of interventions delivered to parents or parents and children/young people were not easily clustered into groups of interventions. We have therefore reported each intervention separately.

1. Behavioural child management programme

Description of evidence

We found 1 systematic review which reviewed 1 study relating to behavioural child management (Egan 1983, cited in Barlow et al. 2006 +) (see Table 26).

Table 26. Study characteristics – Behavioural child management programme

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Studies reported in Barlow et al. (2006 +)					
Egan (1983) (country not reported)	Risk of bias related to allocation concealment rated 'unclear' by reviewers	30	Physically abusive parents	Behavioural child management	Parenting group plus stress management

Description of intervention

A group parenting programme with stress management training aimed at improving parental emotional control, including relaxation skills training and cognitive restructuring.

Narrative summary

Impact on incidence of abuse and neglect

Not measured/reported.

Impact on risk of abuse and neglect

Not measured/reported.

Impact on quality of parenting and parent–child relationships

The study examined effectiveness on a number of aspects of parental behaviour, described in the review as: verbal attacks, verbal commands, verbal reasoning, positive verbals and positive restraints, and family environment (no further information provided). The intervention was no better, and for some measures worse, than the control group on the majority of variables, only showing significant positive changes for the behavioural child management group on:

- behavioural observations of parents saying nothing ($p<0.05$, no effect size given)
- compliance following child positive response ($p<0.05$, no effect size given).

Impact on children's health and wellbeing

Participants in the behavioural child management programme were significantly worse than the comparison group on measures of positive child affect ($p<0.05$, effect size not reported).

Impact on caregiver/parents' health and wellbeing

Unclear – 1 outcome measure relates to 'positive affect' but it is not specified if this is parental positive affect.

Impact on service outcomes

Not measured/reported.

2. Cognitive behavioural therapy

Description of evidence

Two systematic reviews included 1 study of cognitive behavioural therapy, 1 provided to parents (Kolko 1996, cited in Barlow et al. 2006 +), and 1 provided to

parent–child dyads (Runyon et al. 2010, cited in Goldman Fraser et al. 2013 +) (see Table 27).

Table 27. Study characteristics – Cognitive behavioural therapy

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Studies reported in Barlow et al. (2006 +)					
Kolko (1996) (country not reported)	Risk of bias related to allocation concealment rated 'unclear' by reviewers	38	Maltreating (severe punishment and neglect) families	Cognitive behavioural therapy	Family therapy
Studies cited in Goldman Fraser et al. (2013 +)					
Runyon et al. (2010) (USA)	Risk of bias as assessed by reviewers = medium	75	Children ages 7 to 13 years and physically abusive parent	Combined parent–child cognitive behavioural therapy	Active control

Description of intervention

The Kolko (1996) intervention is described as cognitive behavioural therapy, aiming to modify risk factors associated with child physical abuse. This was compared with an ecologically based family therapy (FT) programme focused on family interaction. Both services comprised 12 one-hour weekly clinic sessions with follow-up home sessions to evaluate progress (as reported in Barlow et al. 2006 +).

The intervention carried out in Runyon et al. (2010, cited in Goldman Fraser et al. 2013 +) comprised gradual exposure/construction of a trauma narrative (child group), parent abuse clarification process (parent group) and joint trauma narrative/abuse clarification and negotiation/rehearsal of safety plan (parent-child group). It also incorporated psychoeducation and parent skills training. The intervention comprised 16, weekly group sessions of 2 hours (over a 16- to 20-week period).

Narrative summary

Impact on incidence of abuse and neglect

Not measured/reported.

Impact on risk of abuse and neglect

Not measured/reported.

Impact on quality of parenting and parent-child relationships

One study (Kolko, 1999 cited in Barlow et al. 2006 +) found:

- a significant impact with large effect size on parental anger, as reported by children (SMD=-1.21, 95% confidence interval -1.91 to -0.51)
- a significant impact on family problems with large effect size, as reported by children (SMD=-0.96, 95% confidence interval -1.64 to -0.28)
- non-significant but small to medium effect size impact on parental anger, as reported by parents (SMD=-0.45, 95% confidence interval -1.10 to 0.19)
- no impact on family problems, as reported by parents (SMD=0, 95% confidence internal =-0.64 to 0.64).

A second study (Runyon et al. 2010, cited in Goldman Fraser et al. 2013 +) found that the intervention was associated with increased parental self-reports of positive parenting ($p<0.05$, $d=0.59$) and self-reported reductions in corporal punishment ($p<0.05$, $d=0.57$). However, there was no impact on child reports on both these measures (effect sizes not reported).

Impact on children's health and wellbeing

Runyon et al. (2010, cited in Goldman Fraser et al. 2013 +) found that the combined parent–child cognitive behavioural therapy led to a reduction in parent- and child-reported trauma symptoms ($p<0.05$, $d=0.61$), but not in parent-reported internalising or externalising behaviours.

Impact on caregiver/parents' health and wellbeing

Not measured/reported.

Impact on service outcomes

Not measured/reported.

3. Differential response (family assessment response)

Description of evidence

We found 1 moderate-quality US study (Winokur et al. 2014 +) examining the effectiveness of the differential response model for working with families referred to child protective services (see Table 28).

Table 28. Study characteristics – differential response (family assessment response)

Study	Quality rating	n	Population	Intervention	Comparison group
Winokur et al. (2014 +) (USA)	Moderate	5391	Families assessed as being low to moderate risk, i.e. those with children experiencing mild to moderate general neglect, educational neglect, mild to moderate neglect due to domestic violence, mild to moderate physical abuse	Family assessment response	Investigation response

Description of intervention

Differential response is a dual-track system implemented in a number of US states for responding to child protection concerns. High-risk cases are investigated using a traditional child protection investigation (investigative response). Cases deemed to be low and moderate risk receive an assessment of family needs and strengths without determining whether abuse or neglect has occurred (family assessment response). In the family assessment response track, services are voluntary.

Narrative summary

Impact on incidence of abuse and neglect

Winokur et al. (2014 +) found that there were no differences between the family assessment response and investigative response in terms of overall rates of re-referral, assessments, high risk assessment, opening of a child welfare case or out of home placement within 365 days of initial referral. The only significant difference was in survival analysis of time to high risk assessment, with family assessment response families 18% less likely to have a high risk assessment over time than investigative response families.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children's health and wellbeing

Not measured.

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

Not measured.

4. Early Intervention Foster Care

Description of evidence

We found 1 moderate-quality US RCT (Fisher et al. 2005 +) examining the effectiveness of the Early Intervention Foster Care (EIFC) intervention for fostered children with a history of maltreatment (see Table 29). This study reports outcomes in relation to stability of fostered children's subsequent permanent placements (defined as reunification with birth parents, adoption by relatives, and adoption by nonrelatives). We have categorised this as a 'service outcome', although it could also be judged to have an impact on the child's health and wellbeing.

Table 29. Study characteristics – Early Intervention Foster Care

Study	Quality rating	n	Population	Intervention	Comparison group
Fisher et al. (2005 +) (USA)	Moderate	54	Children aged between 3 and 6 who had been in foster care with a history of maltreatment, and were subsequently in a permanent placement. Children had experienced a range of forms of abuse[22]	Early Intervention Foster Care	Regular foster care

[22] EIFC: sexual abuse 17%, physical abuse 24%, neglect 55%, emotional abuse 4%; RFC: sexual abuse 8%, physical abuse 4%, neglect 84%, emotional abuse 4%.

Description of intervention

Early Intervention Foster Care is an intervention for foster carers (and, where relevant, carers in any subsequent permanent placements) which aims to provide intensive training and support for carers, as well as therapeutic support for fostered children.

Before foster placement, foster parents receive intensive training. After placement they receive support through daily telephone contacts, a weekly foster parent support group and 24-hour on-call crisis support. When a child is entering a permanent placement, the birth parents or adopters are trained in the same skills as the foster parents to support transition. Children receive services from a behavioural specialist and attend weekly therapeutic playgroup sessions.

Key features of the intervention include:

- following a developmental framework, characterising challenges faced by foster preschoolers as delayed development rather than strictly as emotional or behavioural problems
- encouraging prosocial behaviour in the child
- setting consistent limits to address disruptive behaviour
- close supervision of child
- development of a predictable daily routine.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children's health and wellbeing

Not measured.

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

The study found that there was a significantly lower rate of permanent placement breakdown in the EIFC group compared to regular foster care (p=0.02, no effect size reported). Membership of the intervention group appeared to moderate the relationship between number of prior foster care placements and likelihood of permanent placement breakdown, as shown by a statistically significant interaction (p=0.05, no effect size reported). In the regular foster care group, there was a significant association between number of foster care placements and likelihood of placement breakdown, but this association did not hold for the EIFC group, suggesting that EIFC may have negated the impact of prior frequent foster placement moves.

5. Family Behaviour Therapy (FBT)

Description of evidence

We found 1 poor-quality US study examining the effectiveness of family behaviour therapy (FBT) in families with concurrent substance misuse and child neglect (Donohue et al. 2014 -) (see Table 30). The authors also distinguish between parents for whom neglect consists of exposing their child to drug use in-utero or in childhood (termed 'mothers of drug-exposed children'), and those for whom neglect takes other forms, such as lack of supervision (termed 'mothers of non-drug-exposed children'). The study was rated poor because it is not clear how many participants in each condition fell into the above neglect categories. Given that this is a key element of the analysis, this makes it difficult to judge the validity of the study. There is also lack of clarity regarding the methods used for dealing with missing data. The study states that 'all 72 of the qualifying participants who were interested in participating in the study were randomly assigned to treatment (35 FBT, 37 Treatment As Usual) and included in the intent to treat study analyses' (Donohue et a. 2014, p709). However, only 55 people provided data at 6 months, and 58 provided data at 10 months and no method for imputing missing data is reported.

Table 30. Study characteristics – Family Behaviour Therapy (FBT)

Study	Quality rating	n	Population	Intervention	Comparison group
Donohue et al. (2014 -) (USA)	Poor	72 at randomisation, 55 and 58 at follow-up	Mothers (this is specified by the research as opposed to 'parents') who had been reported to the Department of Family Services for child neglect and were using illicit drugs during 4 months prior to referral, and displaying symptoms consistent with illicit drug abuse or dependence at the time of referral	Family behaviour therapy	(TAU) which comprised 'a variety of services that vary according to provider qualifications, duration, intensity and type of services offered' (p711).

Description of intervention

The intervention has been adapted from family behaviour therapy, a 'comprehensive outpatient treatment equipped to manage substance disorders' (Donohue et al. 2014 -, p709). The authors note that FBT 'emphasises cognitive and behavioural skill development through behavioural role-playing, therapeutic assignments and utilisation of family support systems' (p709). It involves implementing the following components: a) helping significant others to provide family-derived rewards for prosocial target behaviours; b) communication skills; c) stimulus control interventions to promote spending time with individuals and situations not involved with substance misuse and other problem behaviours; d) self-control methods to manage drug cravings; e) skills training specific to employment.

In this study, FBT was adapted for use with families by seeing service users at home; treatment session increased from 60 to 75 minutes; duration of treatment increased from 4 to 6 months; target number of treatment sessions increased from 15 to 20; the following intervention components added: a) identification of home hazards; b) improving financial management skills; c) teaching mothers how to

reinforce good behaviours in their children; d) teaching mothers to react to emergent conditions affecting their families; e) HIV and STD prevention.

The intervention was delivered by providers with no previous experience of implementing FBT. Qualifications ranged from bachelor level to doctorate. Providers received approximately 16 hours of training and attended 90 to 120 minutes of weekly group supervision throughout the study.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

This study measured child abuse potential using the Child Abuse Potential Inventory (CAPI; Milner 1986). The study found that FBT was significantly more effective than treatment as usual in reducing child maltreatment potential from baseline to 6 and 10 months post-randomisation in mothers for whom neglect did not take the form of exposing their children to drugs, but other forms such as lack of supervision. The size of this effect was small to medium (partial eta squared =0.081). However, FBT was not significantly more effective than treatment as usual in reducing child abuse potential for those whose neglect did take the form of exposing their children to drugs (no effect size provided).

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children's health and wellbeing

The study measured differences between the intervention and comparison group in terms of the number of days spent by study children in Department of Family Services custody. It was unclear whether this was related to maltreatment incidence, so we have grouped this outcome under 'children's health and wellbeing'. This study found that there was no difference between FBT and treatment as usual in terms of days spent by children in Department of Family Services custody (no effect size provided).

Impact on caregiver/parents' health and wellbeing

This study found that the intervention had mixed impacts on measures of parental health and wellbeing. There was a significant impact of FBT compared to TAU on hard drug use, but only for mothers of non-drug-exposed children, with a small-to-medium effect size at 6 months (partial eta squared =0.076) and a medium effect size at 10 months (partial eta squared =0.107). There was also a significant impact of FBT compared to TAU for both types of neglect on risk of HIV transmission, with a small-to medium effect size at 6 months (partial eta squared =0.056). There was a significant impact of FBT compared to TAU on number of hours worked, with small-to-medium effect sizes at 6 months (partial eta squared =0.054) and 10 months (partial eta squared =0.05.) There was also a marginally significant impact of FBT compared to TAU on days of incarceration at 6 months, with small-to-medium effect size (partial eta squared =0.043), but not at 10 months. However, FBT was not significantly more effective than TAU in terms of reducing marijuana use or alcohol intoxication.

Impact on service outcomes

Not measured.

6. Group-based parenting programme

Description of evidence

We found 1 systematic review which reviewed 1 study relating to what is described simply as a 'group-based based parenting programme' (Wolfe 1981, cited in Barlow et al. 2006 +) (see Table 31).

Table 31. Study characteristics – group-based parenting programme

Study	Quality rating	n	Population	Intervention	Comparison group
Study reported in Barlow et al. 2006 +					
Wolfe (1981) (country unclear)	Risk of bias related to allocation concealment rated 'unclear' by reviewers	16	Physically abusive parents	Group-based parenting programme	Standard services control group

Description of intervention

Parenting group using videotaped vignettes, and self-control using deep muscle relaxation.

Narrative summary

Impact on incidence of abuse and neglect

Agency records for child abuse and maltreatment were compared for intervention and comparison groups. At 1-year follow-up there was no reported abuse in the intervention group, and 1 report in the comparison group. No significance levels or effect sizes are reported, and clearly the low 'n' for this study has meant that it is difficult to discern impact on this variable.

Impact on risk of abuse and neglect

Not measured/reported.

Impact on quality of parenting and parent–child relationships

Child management skills were rated by researchers in the study using the child management subscale of the Parent-Child Interaction Form. There was a statistically significant impact in favour of the intervention group (p=0.01, effect size not reported).

There were no significant differences in caseworker ratings of family treatment needs post-intervention.

Impact on children's health and wellbeing

Child behaviour was assessed using the Eyberg Child Behaviour Inventory (Eyberg and Pincus 1999). No statistically significant differences were reported for either problem intensity (p=0.94) or number of problems (p=0.94).

Impact on caregiver/parents' health and wellbeing

Not measured/reported.

Impact on service outcomes

Not measured/reported.

7. Intensive family preservation intervention (option 2)

Description of evidence

We found 1 poor quality UK quasi-experimental study (Forrester et al. 2013 -) which evaluated the effectiveness of an intensive family preservation intervention ('Option 2') for families involved with child protection services due to concerns related to substance misuse (see Table 32). The study was rated as poor due to the small sample size, and concerns about the comparability of the groups in the quasi-experimental design.

Table 32. Study characteristics – intensive family preservation intervention (option 2)

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Forrester et al. (2013 -)	Poor	27	Families involved with child protection services due to concerns related to substance misuse	Intensive family preservation (Option 2)	No service

Description of intervention

The study describes Option 2 as an intensive family preservation intervention, providing intensive brief input over a 6-week period, combining motivational interviewing and solution-focused approaches.

Narrative summary

Impact on incidence of abuse and neglect

Not measured/reported.

Impact on risk of abuse and neglect

Not measured/reported.

Impact on quality of parenting and parent-child relationships

There was no significant difference between the intervention and control groups in relation to expressiveness or conflict. However, the intervention group was significantly better in relation to family cohesion, with large effect size (d=-1.27, 95% CI -2.30 to -0.24). The control group was also more likely to have a low family functioning score (OR=1.5, 95% CI 0.29 to 7.75).

Impact on children's health and wellbeing

The study found that there was no significant difference in children's behaviour between the intervention and control groups, as measured by the Strengths and Difficulties Questionnaire. Children in the Option 2 group were significantly less likely to have entered care at some point (p=0.001) or be in permanent care (p<0.01).

Impact on caregiver/parents' health and wellbeing

At 5.6 years follow-up, there was a significant reduction in parental use of drugs/alcohol compared to the control group, (OR=12.14, 95% CI 1.19 to 123.62, p<0.05) and reduction in parental psychological stress (OR =0.15 CI 0.03 to 0.85, p<0.05).

Impact on service outcomes

Not measured/reported.

7. I-InTERACT web-based parenting programme

Description of evidence

We found 1 poor quality US pilot RCT (Mast et al. 2014 -) which evaluated the efficacy of a web-based parenting programme: Internet-based Interacting Together Everyday: Recovery After Childhood Traumatic Brain Injury (I-InTERACT), with live coaching designed to improve parenting skills and everyday child functioning for parents of children assessed as having experienced abusive head trauma (determined abusive by hospital multi-disciplinary child abuse team) and scoring 12 or less on the Glasgow Coma Scale (see Table 33). This study was rated as poor quality because there was an extremely small sample size (n=9), with a resulting low level of statistical power (12 to 22% at 0.05 significance criterion – usual standard would be 80%). There is also some inconsistency in data reporting in the paper.

Table 33. Study characteristics – I-InTERACT web-based parenting programme

Study	Quality rating	n	Population	Intervention	Comparison group
Mast et al. (2014 -) (USA)	Poor	9	Parents of children assessed as having experienced abusive head trauma and scoring 12 or less on the Glasgow Coma Scale	I-InTERACT web-based parenting programme	Internet resource comparison (access to a study website with relevant links)

Description of intervention

The I-InTERACT programme is a parenting skills programme which focuses on positive parenting skills and consistent use of discipline. It incorporates content from a number of parenting programmes including parent-child interaction therapy but also helps parents to develop behaviour management techniques to address the difficulties that children who have experienced head injuries may have in learning from consequences. The programme is based on therapy protocol outlined in a manual. The programme also includes content on the behavioural sequelae of head injury as well as communication issues and management of stress. Optional sessions focus on specific ongoing problems which the families may be experiencing such as pain management or guilt.

Sessions are conducted in the family home. The first session is delivered during a home visit but the remainder are delivered online and take the form of a web module (including reading about specific skills, watching videos of parents demonstrating these skills and completing exercises on these skills) and a videoconference session via Skype or Movi Client during which the parents and therapists review the web module and role-play the skills learnt during the web module. The parent then plays with their child and practises these skills while receiving 'bug-in-the-ear' feedback from the therapist. Supplementary sessions included both a web module and videoconference session. Families also appear to have been given access to a website providing information on abusive head trauma.

The intervention was delivered by 'three Master's level research personnel (a research coordinator and 2 advanced clinical psychology doctoral students)' (Mast et al. 2014 -, p490). The 3 'therapists' received training in the sequelae of traumatic brain injury and were instructed on how to deliver the intervention. They also had weekly supervision meetings with a licensed clinical psychologist.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Parent-child interactions (changes in parenting skills and child compliance from pre- to post-test) were assessed using the Dyadic Parent-Child Interaction Coding System (Eyberget al. 2005, cited in Mast et al. 2014 -). Videotaped play sessions (child- and parent-led) were coded. Coding focused on positive parenting behaviours such as reflective statements and behavioural descriptions, and undesirable parenting behaviours such as questions, criticisms, or commands. 'Relative risk' values were calculated, and appear to reflect the relative likelihood of these behaviours in the intervention compared to the comparison group.

This study found a significant difference between groups in parental use of:

- labelled praise with parents in the intervention group being significantly more likely to use labelled praise than those in the comparison group during both child-directed and parent-directed interactions (relative risk values not reported)
- reflective statements with parents in the intervention group being significantly more likely to use reflective statements than those in the comparison group during both child-directed and parent-directed interactions (relative risk, child-directed play =9.35, $p<0.001$; relative risk parent-directed play =16.9, 95% confidence intervals not provided, $p=0.006$)
- parental use of questions with parents in the intervention group being significantly less likely to ask their child questions than those in the comparison group during child-directed interactions (relative risk = 0.31, $p<0.001$).

This study also found a significant difference between groups in child compliance following direct parental commands (during parent-directed interactions) with children in the intervention group being significantly more likely to comply with parental commands than those in the comparison group (effect size not reported).

This study found no significant difference between groups in parental use of commands during child-directed interactions (relative risk =0.66, 0=0.153), nor in

parental use of labelled praise following child compliance during parent-directed interactions.

Impact on children's health and wellbeing

Child wellbeing was assessed using the Eyberg Child Behaviour Inventory (Eyberg and Pincus 1999) and the Child Behaviour Checklist (Achenbach and Rescorla 2000, 2001). Effect sizes relating to analysis of variance were calculated using partial eta squared (note: some effect sizes appear large, even when results are not statistically significant; it is unclear why this is).

This study found a significant difference between groups in scores on the total intensity scale of the Eyberg Child Behavior Inventory, with children in the intervention group scoring significantly lower, with a very large effect size (partial eta-squared =.77, p=0.02).

This study found no significant differences between groups in scores on the total problems scale of the Eyberg Child Behavior Inventory (p=.91, partial eta-squared =0).The study found no significant differences in scores on either the internalising behaviours (p=.64, partial eta-squared=.65), externalising behaviours (p=.61, partial eta-squared =0.07) or total problems (p=.76, partial eta-squared =.03) scales of the Child Behavior Checklist.

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

Not measured.

8. Incredible Years (includes foster carers)

Description of evidence

Two systematic reviews considered studies in which the Webster-Stratton Incredible Years programme was provided to families in which child abuse and/or neglect had occurred (Barlow et al. 2006 +; Goldman Fraser et al. 2013 +), with 1 RCT found in each systematic review. We also found 1 poor-quality UK RCT (Rushton et al. 2010 -) in which a cognitive-behavioural parenting intervention, adapted from the Webster-Stratton programme, was compared with an 'educational' parenting programme, and

a ‘services as usual’ comparison group (see Table 34). This study was rated poor due to the relatively small sample size, and because the analysis has conflated results for the 2 intervention groups, making it difficult to ascertain which approach has led to any improvements in outcomes.

Table 34. Study characteristics – Incredible Years (includes foster carers)

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Studies reported in Barlow et al. 2006 +					
Hughes (2004) (country not reported)	Risk of bias related to allocation concealment rated ‘unclear’ by reviewers	26	Families from child protection agencies	Webster-Stratton Incredible Years Programme	Waiting list control
Studies reported in Goldman Fraser et al. 2013 +					
Linares et al. (2006) (USA)	Risk of bias as rated by reviewers = medium	192	Children in foster care aged 3 to 10 and their biological and foster caregivers	Incredible Years programme (adapted for use with foster and biological parent pairs)	Usual care
Other studies					
Rushton et al. (2010 -) (UK)	Poor	37	Adoptive parents, with children between 3 and 8 years who were screened to have serious behavioural problems early in the placement, and who had experienced maltreatment: neglect (intervention 89%, control 89%), sexual abuse (intervention 21%, control 22%), physical abuse (intervention 58%, control 44%), emotional abuse (intervention 57%, control 33%	Two parenting programmes: 1. Cognitive behavioural approach (adapted from the work of Webster-Stratton 2003) 2. Educational programme – designed specifically for the study	Usual care

Description of intervention

Barlow et al. (2006 +) describe the Webster-Stratton Incredible Years programme as having been 'designed to assist parents in learning how to modify their parenting practices following home visits to assess parent–child interaction' (Barlow et al. 2006 +). The intervention in the Hughes (2004, cited in Barlow et al. 2006 +) study was delivered over the course of 8 weekly 2-hour sessions.

The Incredible Years Adaptation reported in Linares et al. (2006, cited in Goldman Fraser et al. 2013 +) is described as 'a caregiver-directed approach adapted for use with foster and biological parent pairs to address placement issues (e.g., safety; attachment and loss); supplemented with a co-parenting component designed to support a positive, nonconflicted relationship between caregivers and increase caregiver sensitivity' (Goldman Fraser et al. 2013 +, p8). This intervention was delivered over 12 weekly parent group sessions of 2 hours each for biological foster parent pairs, supplemented with weekly sessions (duration not specified) with individual families (biological and foster parent pair and target child).

The cognitive behavioural parenting approach used by Rushton et al. (2010 -) cites the Webster-Stratton programme as its 'most direct influence' (p531) in developing the programme. The content of the programme includes use of praise and rewards, learning clear commands and boundaries, ignoring inappropriate behaviour and giving consequences for unacceptable behaviour. The programme was delivered over 10 sessions.

Narrative summary

Impact on incidence of abuse and neglect

Not measured/reported for either study.

Impact on risk of abuse and neglect

Not measured/reported for either study.

Impact on quality of parenting and parent-child relationships

Hughes et al. (2004, cited in Barlow et al. 2006 +) measured child autonomy, using a non-standardised measure designed specifically for the study. The study found no

significant differences on any of the measures, although there were medium-to-large but non-significant differences favouring the intervention group for:

- parental support for child's autonomy as measured by free play (standardised mean difference =-0.89, 95% confidence interval -1.70 to -0.08)
- parental involvement in free play (standardised mean difference =-0.76, 95% confidence interval -1.56 to 0.04).

In Linares et al.'s (2006, cited in Goldman Fraser 2013 +) study of an adapted version of Incredible Years, to support co-parenting between foster parents and biological parents, significant impact was observed for:

- self-reported positive discipline strategies at both post-intervention ($p<0.05$, small to medium effect size $d=0.40$) and 3-month follow-up ($p<0.01$, medium effect size $d=0.59$)
- self-reported setting of clear expectations at 3-month follow-up, with medium effect size ($p<0.05$, $d=0.54$). (however this was not observed immediately post-intervention)
- improved self-reported co-parenting score with small to medium effect size immediately post-treatment ($p<0.05$, $d=0.48$) (however, this was not sustained at 3-month follow-up).

No differences were observed either post-treatment or at 3-month follow-up for:

- self-reported use of appropriate discipline strategies
- self-reported use of harsh discipline.

The Rushton et al. (2010 -) study found no statistically significant impact of the combined parenting interventions on the majority of measures of parenting, either immediately post-intervention or at 6-month follow-up, although sometimes with small to medium effect size. This study did not find a significant differences between groups at first or second follow-up in scores on the Expression of Feelings Questionnaire ($p=.11$, $d=0.49$, , $p=.26$, $d=0.29$,); the Post Placement Problems scale ($p=.95$, $d=0.01$, $p= .55$, $d=0.21$); the parenting efficacy subscale of the Parenting Sense of Competence Scale ($p=.46$, $d=0.20$, $p= .21$, $d=0.34$); and the frequency

(p=0.4, d=0.25; p=0.68, d=0.13,) and intensity (p=.09, d=0.53; p=.58, d=0.13,) subscales of the Daily Hassles scale.

However, this study found a significant difference between groups with a medium to large effect size at the second follow-up assessment in scores on the Satisfaction with Parenting subscale of the Parenting Sense of Competence Scale in favour of the intervention group (p=.007, d=0.7, 95% CI 8.4 to -1.4), however this had not been significant at the first follow-up assessment (p=.27, d=0.31,).

Impact on children's health and wellbeing

Linares et al. (2006, cited in Goldman Fraser 2013 +) also examined the impact of the adapted version of Incredible Years on children's mental and behavioural health. No significant differences were observed for caregiver-reported behaviour problems using the Child Behaviour Checklist, caregiver reported behavioural and conduct problems using the Eyberg Child Behaviour Inventory or teacher reports of disruptive classroom behaviours.

Similarly, Rushton et al. (2010 -) did not find a significant difference between the intervention groups and usual care on children's psychosocial problems as measured by the Strengths and Difficulties Questionnaire, either immediately post-intervention or at 6-month follow-up. No difference was found in total scores (p=.23, d=0.35; p=.66, d=0.13), impact scores (statistical data not provided) or subscale scores (statistical data not provided). Differences between groups in parental perceptions of their child's progress (level of emotional distress, misbehaviour and attachment) were also non-significant (statistical data not provided).

Impact on caregiver/parents' health and wellbeing

Not measured/reported.

Impact on service outcomes

Not measured/reported.

9. Keeping Foster and Kinship Carers Trained and Supported (KEEP)

Description of evidence

One systematic review (Goldman Fraser et al. 2013 +) reviewed 2 studies relating to the Keeping Foster and Kinship Carers Trained and Supported (KEEP) intervention.

One of the included studies contained no outcomes relevant to this review, so we have included just 1 study (Chamberlain 2008, cited in Goldman Fraser et al. 2013 +). (see Table 35)

Table 35. Study characteristics – Keeping Foster and Kinship Carers Trained and Supported (KEEP)

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Studies reported in Goldman Fraser et al. 2013 +					
Chamberlain (2008) (USA)	Risk of bias as rated by reviewers = medium	700	Caregivers of foster children ages 5 to 12	KEEP	Usual care

Description of intervention

Keeping Foster and Kinship Carers Trained and Supported (KEEP) is described as a parent training intervention to increase foster/kin caregivers' use of positive discipline strategies. Delivered by paraprofessionals, it employs role-play, videotapes and homework practice.

The intervention comprises 16 weekly parent group sessions of 1.5 hours each, with 15-minute didactic presentations by facilitators and then group discussion related to primary curriculum concepts.

Narrative summary

Impact on incidence of abuse and neglect

Not measured/reported.

Impact on risk of abuse and neglect

Not measured/reported.

Impact on quality of parenting and parent-child relationships

The systematic review reports that 'the authors examined parent daily report of child problem behaviours and use of positive reinforcement, assessed 5 month postbaseline. Proportion of positive reinforcement (R+) was calculated as a ration of R+' (Goldman Fraser et al. 2013 +, p48).

The study found a significant impact with small effect size of the intervention on proportion of positive reinforcement (p=significant (figure not reported), d=0.29).

Impact on children's health and wellbeing

The study also examined parent-reported behaviour problems. There was a significant positive impact of the intervention, with small effect size, on child behaviour problems (p=significant (figure not reported), d=0.26).

Impact on caregiver/parents' health and wellbeing

Not measured/reported.

Impact on service outcomes

Not measured/reported.

10. Multi-systemic therapy

Description of evidence

We found 1 moderate-quality systematic review (Barlow et al. 2006 +) which cited 1 study which had compared multi-systemic therapy with parent training sessions (Brunk et al. 1987, cited in Barlow et al. 2006 +), and 1 moderate-quality US RCT (Swenson et al. 2010 +) which compared the effectiveness of multisystemic therapy adapted for use with child abuse and neglect (MST-CAN) versus enhanced outpatient treatment (EOT) in improving youth mental health problems, parent psychiatric distress and parenting behaviours associated with maltreatment. The participants were youths and parents with a CPS record and history of physical abuse (see Table 36).

Table 36. Study characteristics – multi-systemic therapy

Study	Quality rating	n	Population	Intervention	Comparison group
Studies cited in Barlow et al. 2006 +					
Brunk et al. (1987)	Risk of bias related to allocation concealment rated 'unclear' by reviewers	43	Abusive or neglectful families	Parent training	MST
Other studies					

Swenson et al. (2010 +) (USA)	Moderate	86	Young people (10 to 17 years old) and parent who was implicated in the CPS report of physical abuse.	MST-CAN	Enhanced outpatient treatment

Description of intervention

Multi-systemic therapy (MST) is a treatment originally developed for use with young offenders (Henggeler et al. 2009, cited in Swenson et al. 2010 +). The principal features of MST include addressing the multi-determined nature of serious clinical problems, working with the family to achieve behaviour change, delivering services in the home to overcome barriers to service access, integrating evidence-based interventions with the delivery of MST and using a comprehensive quality assurance system to support therapist fidelity (Swenson et al. 2010 +). In the Swenson et al. (2010 +) study, the intervention has been adapted for use with child abuse and neglect.

Swenson et al. (2010 +) state that the standard length of an MST intervention is 4-6 months. However, in the Swenson et al. (2010 +) study this was allowed to be extended, depending on the requirements of the family. In the Brunk et al. (1987) study the intervention was delivered in 8 weekly sessions of 1.5 hours duration. For the Swenson et al. (2010 +) study all therapists in both intervention and comparison groups had masters degrees in clinical counselling, social work or psychology and at least 1 year of prior clinical experience.

Narrative summary

Impact on incidence of abuse and neglect

One study (Swenson et al. 2010 +) examined the impact of MST-CAN on recurrence of child abuse and neglect, as measured by any new report of abuse of the target child, or abuse of any child by the target parent, with information obtained from child protective services records. The study found no significant impact of the intervention compared to the comparison group on recurrence of abuse and neglect ($p=0.198$, no effect size reported).

However, Swenson et al. (2010 +) found that MST-CAN had a significantly greater impact than enhanced outpatient treatment on a variety of measures of self-reported abusive behaviours including:

- youth and parent-reported levels of neglect – significantly greater decrease in MSTCAN than EOT group (youth-reported $p<0.01$, $d=0.89$; parent-reported $p<0.01$, $d=0.28$)
- youth and parent-reported severe assault (youth-reported $p<0.01$, $d=0.54$; parent-reported $p<0.01$ $d=0.57$)
- youth-reported psychological aggression ($p<0.01$, $d=0.21$) although not parent-reported)
- youth-reported minor assault ($p<0.01$ $d=0.14$) although not parent-reported
- youth and parent-reported non-violent discipline (youth-reported $p <0.01$ $d=0.20$; parent-reported $p<0.01$, $d=0.57$).

The study also found that youth who received MST-CAN were significantly less likely to experience an out-of-home placement over 16 months than were youth in the EOT condition, with small to medium effect size (Chi-squared =3.74, $p<0.05$, phi=0.21).

Impact on risk of abuse and neglect

Not reported for either study.

Impact on quality of parenting and parent–child relationships

Both studies found, overall, that MST/MST/CAN had a positive impact on quality of parenting and parent–child relationships.

Brunk et al. (1987, cited in Barlow et al. 2006 +) found that MST (and parent training) both resulted in significant impact on parental effectiveness-attention ($p<0.029$, no effect size) and on child passive non-compliance ($p=0.012$, no effect size).

Impact on children's health and wellbeing

Swenson et al. (2010 +) found a positive impact on 5 of the 10 measures of young people's health and wellbeing at 16 months post baseline. These were:

- youth-reported PTSD symptoms ($p<0.05$, $d=0.68$)
- parent-reported PTSD ($p<0.05$,$d=0.55$)

- youth-reported dissociative symptoms ($p<0.05$, $d=0.73$)
- parent-reported internalising behaviours ($p<0.05$, $d=0.71$)
- parent-reported total symptoms ($p<0.01$, $d=0.85$).

However, no differences were observed on the remaining 5 scales:

- parent-reported externalising behaviours
- parent ratings of youth social skills
- youth reported depression, anxiety and anger
- impact on caregiver/parents' health and wellbeing.

There was mixed evidence regarding the impact of MST/MST-CAN on caregiver/parents' health and wellbeing, with a slightly greater weight of evidence in favour of impact.

Brunk et al. (1987, cited in Barlow et al. 2006 +) found that parents receiving MST showed a reduction in overall stress ($p=0.011$) and therapist-reported family problems ($p=0.007$), but not for social system problems.

Swenson et al. (2010 +) found that MST-CAN parents showed significantly greater decrease in psychiatric distress as measured by the Global Severity Index of the Brief Symptom Inventory (Derogatis 1975, cited in Swenson et al. 2010 +) than those in the enhanced outpatient treatment condition ($p<0.05$, $d=0.63$) but not in the number of overall symptoms.

There was also significant increases reported in MST-CAN parents in total ($p<0.01$, $d=0.46$), appraisal ($p<0.01$, 0.67) and belonging social support ($p<0.05$, 0.57), whereas enhanced outpatient treatment counterparts did not experience this.

Impact on service outcomes

Not measured.

11. Nurse home visiting

Description of evidence

One systematic review reviewed 1 effectiveness trial comparing a high-intensity nurse home visitation intervention (loosely derived from the Family Nurse

Partnership) with usual care (Macmillan et al. 2005, cited in Goldman Fraser et al. 2013 +) (see Table 37).

Table 37. Study characteristics – nurse home visiting

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Studies reported in Goldman Fraser et al. 2013+					
Macmillan et al. (2005) (Canada)	Risk of bias as rated by reviewers = low	163	Physically abused or neglected children aged 13 years or younger and their families	Nurse home visitation	Usual care

Description of intervention

A caregiver-directed approach offering intensive family support, parent education, and referrals to health and social services (derived from Olds et al. 1997 home visiting preventive intervention in which the authors developed their own manual). Employs mutual problem identification, goal-setting and problem-solving strategies, supporting positive parent–child interaction.

The intervention lasted a total of 24 months, comprising 6 months of 1.5-hour weekly home visits with parent, then visits every 2 weeks for 6 months, then monthly visits for 12 months.

Narrative summary

Impact on incidence of abuse and neglect

Not measured/reported.

Impact on risk of abuse and neglect

Risk of abuse and neglect was measured using the Child Abuse Potential Inventory (Milner 1986). There was no significant impact of the intervention on CAPI scores (p=NS, effect size not reported).

Impact on quality of parenting and parent–child relationships

The study found:

- no impact on child rearing attitudes, as measured by the Adult Adolescent Parenting Inventory (p=NS, effect size not reported)

- no impact on improvements in the quality of the child's environment, as measured using the HOME scale (p=NS, effect size not reported)
- no impact on improvements in family functioning, as measured using the McMaster Family Functioning – General Functioning scale (p=NS, effect size not reported).

Impact on children's health and wellbeing

Children's behavioural problems were measured using the Revised Behavioural Problems checklist. The study found no impact on:

- attentional problems (p=NS, effect size not reported)
- anxiety/withdrawal (p=NS, effect size not reported)
- psychotic behaviour (p=NS, effect size not reported)
- conduct disorder symptoms (p=NS, effect size not reported)
- socialised aggression (p=NS, effect size not reported)
- excessive motor tension (p=NS, effect size not reported).

Impact on caregiver/parents' health and wellbeing

Not measured/reported.

Impact on service outcomes

Not measured/reported.

12. Project Support

Description of evidence

We found 1 moderate quality RCT (Jouriles et al. 2010 +) which examined the effectiveness of the Project Support intervention in a sample of families referred for child maltreatment (see Table 38).

Table 38. Study characteristics – Project Support

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Jouriles et al. (2010 +) (USA)	Moderate	35	Families referred for child maltreatment	Project Support (home-based intervention)	Services as usual

Description of intervention

Project Support is described as a home-based intervention involving 2 primary components: 1) teaching mothers child behaviour management skills; and 2) providing instrumental and emotional support to mothers. The authors hypothesise that the primary mechanism for reducing maltreatment is the child behaviour management skills component. Mothers are taught skills with which to increase desirable, and decrease undesirable, child behaviours and facilitate a positive and warm relationship. This is taught through direct instruction, practice and feedback. The social and instrumental support components involve training mothers in decision-making and problem-solving skills, for example maintaining adequate food with limited financial resources.

The intervention was designed to include weekly one to one sessions of 1.5 to 2 hours duration for up to 8 months. There was not a specific set number of sessions – the intervention was structured so that it could be delivered flexibly within the 8-month period. The intervention team consisted of a therapist and 1 or more advanced undergraduate or post-baccalaureate students.

Narrative summary

Impact on incidence of abuse and neglect

The study measured recurrence of maltreatment in terms of subsequent referrals to child protective services. There was no significant difference between the intervention and comparison group on this measure, but with small to medium effect size (p=0.086, phi=0.29).

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent–child relationships

This study found a significant impact of the intervention on parenting quality, compared to the comparison group, with large effect sizes, on all 3 measures:

- self-reported inability to manage childbearing responsibilities, measured using the Parenting Locus of Control Scale (PLOC) (ES=1.02. 95% CI [0.29, 1.70])

- self-reported harsh parenting behaviours, measured using the psychological aggression and minor assault subscales from the Revised Conflict Tactics Scales (CTS-R) (ES=0.86, 95% CI [0.15, 1.53])
- observed ineffective parenting (ES=0.96, 95% CI [0.24, 1.64]).

Impact on children's health and wellbeing

Not measured.

Impact on caregiver/parents' health and wellbeing

This study found that the intervention did not have a significant impact on mothers' psychological distress (no effect size provided).

Impact on service outcomes

Not measured.

13. SafeCare

Description of evidence

We found 1 systematic review which reviewed a RCT exploring the effectiveness of SafeCare in comparison to services as usual (Chaffin et al. 2012, cited in Goldman Fraser et al. 2013 +) (see Table 39).

Table 39. Study characteristics – SafeCare

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Studies reported in Goldman Fraser et al. (2013+)					
Chaffin et al. (2012) (USA)	Risk of bias as rated by reviewers = low	2175	Children up to age 12 and their maltreating parents involved with child protective services	SafeCare	Services as usual

Description of intervention

SafeCare is described as a home-based, multifaceted parent intervention to prevent and treat child abuse and neglect. The services address parent–child or parent–infant interaction, parental stress and home safety risks including behaviour management, problem solving, infant and child health and nutrition, and social support. The intervention comprises weekly home visits for at least 6 months.

Narrative summary

Impact on incidence of abuse and neglect

The study investigated impact on recurrence of abuse and neglect, as measured by reports to child protective services. Two analytic strategies were used to investigate the relationships, both aiming to equalise differences between home visitors. We report here the data from the 4- rather than 6-strata propensity stratification as more cases were included in this analysis, and it results in a more conservative estimate of effect size.

The study found that SafeCare had a significant positive impact on recurrence of abuse and neglect, in:

- the full population for the study (p=0.03, hazard ratio = 0.83, 95% confidence interval =0.70 to 0.98)
- a subgroup comprising preschool age children (p=0.016, hazard ratio =0.74, 95% confidence interval =0.58 to 0.95).

Impact on risk of abuse and neglect

Not measured/reported.

Impact on quality of parenting and parent-child relationships

Not measured/reported.

Impact on children's health and wellbeing

Not measured/reported.

Impact on caregiver/parents' health and wellbeing

Not measured/reported.

Impact on service outcomes

Not measured/reported.

15. Trauma-informed parent training for adoptive parents

Description of evidence

We found 1 moderate quality US RCT (Purvis et al. 2015 +) which explored the impact of a trauma-informed 'trust-based relational intervention' for adoptive parents

on behavioural problems and trauma symptoms in adopted children who have been abused (see Table 40).

Table 40. Study characteristics – trauma-informed parent training for adoptive parents

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Purvis et al. (2015 +) (USA)	Moderate	96	Adoptive parents of children aged 5 to 12 who have suffered early adversity (neglect 75%, physical abuse 33%, sexual abuse 15%)	Trust-based relational intervention	Waitlist, and online training after study completion

Description of intervention

The intervention is a 4-day group parent training intervention. It is based on 3 principles that seek to improve outcomes for vulnerable children. The principles are:

- empowering principles aiming to help caregivers develop the child's capacity for self-regulation and decrease negative and disruptive behaviour
- connecting principles aiming to help build trusting relationships and connect the other 2 principles
- correcting principles to shape behaviour and responses.

Each of these principles is linked to strategies. Empowering principles are linked to ecological strategies and psychological strategies, connecting principles to mindful awareness and engagement strategies and correcting principles to proactive strategies and responsive strategies.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children's health and wellbeing

The study found that children in the intervention group showed significantly more improvement in behaviour on a number of measures including:

- Four of the 5 subscales of the Strengths and Difficulties Questionnaire (emotional problems with small effect size, partial eta squared =0.04; conduct problems with small effect size, partial eta squared =0.04; hyperactivity/inattention with small to medium effect size, partial eta squared =0.09; and prosocial behaviour with small effect size, partial eta squared =0.05. No significant difference for peer problems).
- Total difficulties as measured by the Strengths and Difficulties Questionnaire, with small to medium effect size (partial eta squared =0.09).
- Trauma symptoms as measured by the Trauma Symptoms Checklist including anxiety (with small effect size, partial eta squared =0.04), depression with small effect size (partial eta squared =0.04), anger and aggression with small effect size (partial eta squared =0.06), post-traumatic stress (PTS) arousal, with small to medium effect size (partial eta squared =0.09). There was no significant difference on PTS intrusion, PTS avoidance, PTS total, dissociation or sexual concerns.

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

Not measured.

14. Wraparound facilitation

Description of evidence

We found 1 moderate quality Canadian RCT (Browne et al. 2014 +) which evaluated the effectiveness of a 'wraparound facilitation' intervention compared to usual child protection services (see Table 41).

Table 41. Study characteristics – wraparound facilitation

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Browne et al. (2014 +)	Moderate	135	Families with substantiated investigation for child maltreatment and their	Wraparound facilitation	Child protection services as usual

(USA)			children (mean age = 6.45 years)		

Description of intervention

The study describes wraparound facilitation as 'a planning strategy that links children and families with an individualized constellation of service agencies and existing supports' (Lyons 2004, p2). Families in the intervention condition were allocated a masters-level social worker as a wraparound facilitator who supports them to create a support network of friends, family members, formal and informal supports and to develop an action plan. The key elements of the intervention are identified as: 1) promoting family voice and choice; 2) providing care that is embedded in the child and family team; 3) drawing on supports in the family's context; 4) collaboration among all informal and formal team members; 5) provision of community-based care; 6) ensuring cultural sensitivity; 7) individualised care plan; 8) strengths-based model; 9) persisting in the face of challenges; 10) outcome-based evaluation.

Narrative summary

Impact on incidence of abuse and neglect

Not measured/reported.

Impact on risk of abuse and neglect

Not measured/reported.

Impact on quality of parenting and parent-child relationships

Not measured/reported.

Impact on children's health and wellbeing

The study found no significant difference between the intervention and control group in improvements in levels of children's impairment (p=non-significant, d=0.14, 95% CI -0.12 to 0.52), ratings of behavioural and emotional strengths (p=non-significant, d=-0.24, 95% CI-0.37 to 0.29) or attainment of developmental milestones (p=non-significant, d=-0.02, 95% CI -0.53 to 0.49).

Impact on caregiver/parents' health and wellbeing

The study found no significant difference between the intervention and control group in improvements in levels of maternal depression (p=non-significant, d=0.25, 95% CI -0.07 to 0.57) or parental stress (p=non-significant, d=0.10, 95% CI -0.19 to 0.40).

Impact on service outcomes

Not measured/reported.

16. Group programme for children and women affected by intimate partner violence

Description of evidence

We found 1 poor quality US RCT (Graham-Bermann et al. 2015 -) which explored the impact of an intervention comprising a 'kids club' for preschool age children and an empowerment group for mothers on children's internalising behaviours following exposure to intimate partner violence (see Table 42). The study was rated as poor due to inconsistent reporting of analyses in the results and discussions sections, which mean the results of the study are not clear.

Table 42. Study characteristics – group programme for children and women affected by domestic violence

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Graham-Bermann et al. (2015 -)	Poor	120	Children aged 4 to 6 who have been exposed to intimate partner violence (IPV) and their mothers	Pre Kids Club (for children) and Moms' Empowerment Programme (for mothers)	Waitlist

Description of intervention

The intervention has 2 components: a 'Pre Kids Club' (PKC)[23] intervention for children and the Moms' Empowerment Programme (MEP) group intervention for mothers. The PKC involves discussing issues related to intimate partner violence in an age-appropriate way, using a training manual. MEP is designed to support

[23] Referred to as 'Pre Kids Club' as adapted from 'Kids Club' which is for school-age children.

mothers' social and emotional adjustment. As part of the intervention mothers are supported to:

- discuss the impact of IPV on their child
- discuss their mental health symptoms
- normalise and reduce stress
- provide support regarding parenting challenges.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children's health and wellbeing

For internalising behaviour, the results of the multi-level regression analysis using an intent-to-treat approach showed a significant treatment by time interaction, however it is unclear whether this is in favour of the intervention or control group. The discussion states that there was an improvement in internalising symptoms for girls only. However, this does not match the findings as reported elsewhere in the study. The results of the study are therefore unclear.

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

Not measured.

Narrative summary of the evidence – question 16

1. Cognitive behavioural therapy

Description of evidence

We identified 3 systematic reviews which reviewed evidence in relation to cognitive behavioural therapy (CBT) (Goldman Fraser et al. 2013 +, Leenarts et al. 2013 -, Macdonald et al. 2012 ++). We also identified 2 poor quality randomised control trials from the USA (Barbe et al. 2004 -; Shirk et al. 2014 -). These were rated as poor due to low sample size and because male participants were not included in final analysis due to low number (Shirk et al. 2014 -) (see Table 43).

Goldman Fraser et al. (2013 +) reviewed 3 RCTs evaluating the effectiveness of trauma-focused CBT for children and young people up to the age of 14 with experience of sexual abuse. The review reports results as described by the authors of individual studies.

Leenarts et al. (2013 -) reviewed 5 RCTs evaluating the effectiveness of a variety of cognitive behavioural therapies for children and young people up to the age of 17 with experience of sexual abuse. It is not clear whether the effectiveness data reported in the review were provided by the authors of individual studies or calculated by the reviewers. Similarly, the direction of effects are not reported and although effect sizes appear to correspond to Cohen's d, this is not made clear.

Macdonald et al. (2012 ++) reviewed 10 RCTs reported in 15 papers examining the effectiveness of CBT for children and young people up to the age of 18 who have experienced sexual abuse. Standardised SMDs were calculated for each outcome, with measurements taken at different time points grouped under the broad categories of short term (immediately after treatment), medium term (3-6 months after treatment) and long term (at least 1 year after treatment). On the basis of the information reported in the review it is not possible to determine the studies or papers from which the meta-analysis results are calculated.

A number of studies are reported on multiple occasions in Goldman Fraser et al. (2013 +), Leenarts et al. (2013 -), and Macdonald et al. (2012 ++). Where this occurs, we have reported that study's results based on Macdonald et al. (2012 ++) as this review reports on a meta-analysis and was assessed as being of higher

quality than Goldman Fraser et al. (2013 +), or Leenarts et al. (2013 -). However, in the small number of instances where an outcome was not used in Macdonald et al. (2012 ++) but is reported in another systematic review, this data has been reported in the narrative summary.

Table 43. Study characteristics – cognitive behavioural therapy

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Studies reported in Goldman Fraser et al. 2013 + which were relevant to question 16					
Cohen et al. (1996) (results for this study are reported in Macdonald et al. 2012 unless outcomes or measures differ)	Medium	86	Sexually abused pre-schoolers (ages 2.11 to 7.1, mean age =4.68)	Cognitive behavioural therapy (trauma-focused)	Active control (derived comparator)
Cohen et al. (2004) (results for this study are reported in Macdonald et al. 2012 unless outcomes or measures differ)	Low	229	Sexually abused children (ages 8 to 14.11 years, mean age =10.76)	Cognitive behavioural therapy (trauma-focused)	Active control (conventional child-centred therapy)
Deblinger et al. (2001) (results for this study are reported in Macdonald et al. 2012 unless outcomes or measures differ)	Medium	44	Sexually abused young children (ages 2 to 8 years, mean age 5.45)	Cognitive behavioural therapy (trauma-focused, group format)	Active control (conventional supportive parent group)
Studies reported in Leenarts et al. 2013 - which were relevant to question 16					
Cohen et al. (2004) (results for this study are reported in Macdonald et al. 2012 unless outcomes or measures differ)	Risk of bias rated for a number of areas but not combined in a total score	229	Sexually abused children (ages 8 to 14.11 years, mean age =10.76)	Cognitive behavioural therapy (trauma-focused)	Active control (conventional child-centred therapy)
Cohen et al. (2005) (results for this study are reported in Macdonald et al. 2012)	Risk of bias rated for a number of areas but not	82	Sexually abused children between the ages of 8 and 15 (32% male)	Cognitive behavioural therapy (trauma-focused)	Active control (non-directive supportive therapy)

	combined in a total score				
Deblinger et al. (2001) (results for this study are reported in Macdonald et al. 2012)	Risk of bias rated for a number of areas but not combined in a total score	67	Sexually abused children between the ages of 2 and 8 (39% male)	Cognitive behavioural therapy (group format)	Active control (supportive counselling)
Deblinger at al. (2011)	Risk of bias rated for a number of areas but not combined in a total score	210	Sexually abused children between the ages of 4 and 11 (39% male)	Cognitive behavioural therapy (trauma-focused) with or without trauma narrative component in 8 vs 16 sessions	Not clear
King et al. (2000) (results for this study are reported in Macdonald et al. 2012)	Risk of bias rated for a number of areas but not combined in a total score	36	Sexually abused children between the ages of 5 and 17 (31% male)	Child cognitive behavioural therapy or family cognitive behavioural therapy	Waitlist control
Trials/studies reported in Macdonald et al. 2012 ++. All included studies were relevant to Q16. The authors conducted a meta-analysis and results for individual studies are therefore not reported separately					
Berliner and Saunders (1996)	Risk of bias rated for a number of areas but not combined in a total score	154	Children between the ages of 4 and 13 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused	Active control (described by review authors as treatment as usual which was usually supportive, unstructured psychotherapy)

Burke (1988)	Risk of bias rated for a number of areas but not combined in a total score	25	Children between the ages of 8 and 13 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused	Waitlist control
Celano et al. (1996)	Risk of bias rated for a number of areas but not combined in a total score	49	Children between the ages of 8 and 13 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused	Active control (described by review authors as treatment as usual which was usually supportive, unstructured psychotherapy)
Cohen et al. (1996) (3 trials)	Risk of bias rated for a number of areas but not combined in a total score	86	Children between the ages of 3 and 6 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused	Active control (described by review authors as treatment as usual which was usually supportive, unstructured psychotherapy)
Cohen et al. (1998) (2 trials)	Risk of bias rated for a number of areas but not combined in a total score	82	Children between the ages of 7 and 15 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused	Active control (described by review authors as treatment as usual which was usually supportive, unstructured psychotherapy)

Cohen et al. (2004) (2 trials)	Risk of bias rated for a number of areas but not combined in a total score	229	Children between the ages of 8 and 14 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused	Active control (described by review authors as treatment as usual which was usually supportive, unstructured psychotherapy)
Deblinger et al. (1996) (2 trials)	Risk of bias rated for a number of areas but not combined in a total score	100	Children between the ages of 7 and 13 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused. This intervention was delivered in group format	Active control (described by review authors as treatment as usual which was usually supportive, unstructured psychotherapy)
Deblinger et al. (2001)	Risk of bias rated for a number of areas but not combined in a total score	54	Children between the ages of 2 and 8 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused	Active control (described by review authors as treatment as usual which was usually supportive, unstructured psychotherapy)
Dominguez (2001)	Risk of bias rated for a number of areas but not combined in a total score	32	Children between the ages of 6 and 17 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused	Active control (described by review authors as treatment as usual which was usually supportive, unstructured psychotherapy)

King et al. (2000)	Risk of bias rated for a number of areas but not combined in a total score	36	Children between the ages of 5 and 17 with experience of sexual abuse	The review aimed to evaluate cognitive behavioural therapy programmes and the authors describe the majority as trauma-focused	Active control (described by review authors as treatment as usual which was usually supportive, unstructured psychotherapy)
Other studies					
Barbe et al. (2004)	Poor	107 participants were randomised but analysis is restricted to the 72 participants assigned to either cognitive behavioural therapy (n=37) or nondirective supportive therapy (n=35) as only 1 participant assigned to systemic behavioural family therapy was determined to have experienced sexual abuse	Adolescents between the ages of 13 and 18 meeting criteria for DSM-III-R major depression with a score greater than or equal to 13 on the Beck Depression Inventory. History of sexual abuse was determined for a subset of this sample	Cognitive behavioural therapy	Non-directive supportive therapy and Systemic behavioural therapy (note: participants assigned to this intervention were excluded from analysis as only 1 participant was determined to have experienced sexual abuse)
Shirk et al. (2014)	Poor	43 randomised, 35 completed 16 week assessments. Only females were	Adolescents of average age 15.25 (m-CBT group) and 15.69 (control group) years; 67%	cognitive behavioural treatment modified to address specific consequences of interpersonal trauma	Usual care

		included in analysis due to limited number of males in the sample, and because no males had observations for sessions 8 or 12 in m-CBT group	had been sexually abused		

Description of intervention

Macdonald et al. (2012 ++) describe cognitive behavioural treatment as deriving from 4 theories of learning: '… respondent conditioning (associative learning); operant conditioning (the effect of the environment on patterns of behaviour); observational learning (learning by imitation); and cognitive learning (the impact of thought patterns on feelings and behaviour)' (p13). The authors state that children who experience sexual abuse may experience '… psychobiological changes that contribute to the development and maintenance of post-traumatic stress symptoms …' (p14). These include affective, behavioural, cognitive, complex PTSD and psychobiological trauma symptoms. Cognitive behavioural therapy is described as being designed to address these symptoms through a range of techniques. For example:

- emotional distress: children helped to cope with emotional distress, for example through learning about relaxation and emotional expression skills
- anxiety: children taught to recognise the signs of anxiety, and how to replace maladaptive responses to anxiety with adaptive ones
- behaviour problems: parents supported to understand the impact of sexual abuse on children's behaviour, and how this is shaped or maintained by consequences.

The length of the interventions evaluated in this review ranged between 6 and 20 sessions and many also involved a non-offending caregiver. For those which did include a non-offending caregiver some were delivered through joint child–caregiver sessions, others involved individual sessions for both the child and their caregiver (and sometimes included a joint session as well), while other trials included as 1 of the experimental conditions an intervention which was only delivered to the caregiver (Deblinger et al. 1996). Some of the interventions also appear to have been delivered in group format (e.g. Burke et al. 1988; Celano et al. 1996).

Goldman Fraser et al. 2013 (+) describe the treatment programmes evaluated in the 3 studies relevant to question 16 as trauma-focused cognitive behavioural therapy which aims to reduce maladaptive responses to sexual abuse exposure or other traumatic events. The key objectives of treatment are to enhance the child's ability to express feelings; recognise the relationship between behaviours, feelings and thoughts; and to develop coping skills. The programmes involve 'gradual exposure'

or creation of the trauma narrative, cognitive processing of traumatic event, psychoeducation in relation to child sexual abuse and body safety, and support for parents in relation to behavioural management. Participants received between 12 and 16 weekly sessions which lasted for between 1 and 1.5 hours. Sessions were delivered individually to both children and parents, and jointly to children and parents.

The intervention evaluated by Deblinger at al. (2011, reported in Leenarts et al. 2013 -) is described as trauma-focused cognitive behavioural therapy with or without a trauma narrative component in 8 vs 16 sessions. (Note: no further details are provided and it is not clear what the experimental and control conditions include.)

The intervention described in Shirk et al. (2014 -) is an individual cognitive behavioural therapy for depressed adolescents with a history of interpersonal trauma (physical, sexual and/or emotional abuse) delivered in 2 outpatient clinics over 12 weeks with weekly sessions guided by a manual. The intervention has been specifically modified to address the consequences of interpersonal trauma. Components of the sessions include looking at mood and cognition, mood and activities, and mood and interpersonal relationships.

Barbe et al. (2004 -) provides little detail on the cognitive behavioural intervention being evaluated except to note that it is derived from Beck et al. (1979), and was comprised of 12 to 16 sessions delivered on a weekly basis. Similarly, little detail is provided in relation to the comparison intervention other than noting that it is designed to '… control for the nonspecific effects of psychotherapy and consisted of the provision of support, affect clarification, and active listening' (p 78).

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

1. Parental belief and support of the child

A meta-analysis conducted by Macdonald et al. (2012 ++) found that cognitive behavioural therapy had a positive impact on parental belief and support of the child (measured using the Parental Support Questionnaire or the Parents Reaction to Incest Disclosure Scale), with small effect size, immediately after treatment (standardised SMD 0.30, 95% CI 0.03 to 0.57). Small and very small effect sizes were observed in the intermediate term (3 to 6 months after treatment; standardised SMD -0.32, 95% CI-0.65 to 0.01) and in the longer term (at least 1 year; standardised SMD -0.10, 95% CI-0.43 to 0.23).

2. Parental attributions

A meta-analysis conducted by Macdonald et al. (2012 ++) found that cognitive behavioural therapy was found to have medium or large, but non-significant, impacts (follow-up point unclear) on parental self-blame (mean difference 0.80, 95% CI -4.03 to 2.43), child blame (mean difference -1.20, 95% CI -4.47 to 2.07), perpetrator blame (mean difference -0.60, 95% CI -2.62 to 1.42) and negative impact (mean difference -1.90, 95% CI -4.67 to 0.87). (Note: all outcomes measured using the Parental Attribution Score.)

3. Parenting skills

A meta-analysis conducted by Macdonald et al. (2012 ++) found that cognitive behavioural therapy had a large effect on parenting skills (measured using the Parenting Practices Questionnaire) in the short term (mean difference 3.86, 95% CI 0.47 to 7.26). The intervention also had an impact on parenting skills in the intermediate term (mean difference 2.36, 95% CI -1.55 to 6.28) and in the long term (mean difference 0.89, 95% CI -4.89 to 3.11); however these were not statistically significant. (Note: these results are also reported in Goldman Fraser et al. 2013 + for both Cohen et al. 2004 and Deblinger et al. 2001; but as Macdonald provides meta-analysis results and is of a higher quality the NCCSC has not reported them here.)

4. Parental emotional reactions

A meta-analysis conducted by Macdonald et al. (2012 ++) found that cognitive behavioural therapy had a large effect on parents' emotional reactions (measured using the parent's emotional reactions questionnaire) in terms of total scores (follow-

up point unclear, mean difference -5.17, 95% CI -7.17 to -3.17), and in the short term (mean difference -6.95, 95% CI -10.11 to -3.80), the intermediate term (mean difference -3.46, 95% CI -6.98 to 0.06) and the long term (mean difference -4.56, 95% CI -8.37 to -0.75).

Impact on children's health and wellbeing

1. Post-traumatic stress disorder symptoms

A meta-analysis conducted by Macdonald et al. (2012 ++) found that cognitive behavioural therapy had small to medium effects on post-traumatic stress disorder symptoms measured using a range of scales in the short (standardised mean difference; -0.44; 95% CI -0.73 to -0.16), intermediate (standardised mean difference; -0.39; 95% CI -0.74 to -0.04) and long term (standardised mean difference; -0.38; 95% CI -0.65 to -0.11).

Deblinger et al. (2011, reported in Leenarts et al. 2013 -) found that cognitive behavioural therapy had small effects at post-test on re-experiencing (mean 0.35, significance value not reported, direction of effect not reported); avoidance (mean 0.35, significance value not reported, direction of effect not reported); and hyper-vigilance (mean 0.23, significance value not reported, direction of effect not reported). As the direction of effect in relation to this outcome is not reported the NCCSC is not sufficiently confident to include this data in the corresponding evidence statement.

Cohen et al. (2004, reported in Goldman Fraser et al. 2013 +) found that participants in the intervention group showed significantly greater decreases in avoidance of reminders of traumatic event with a medium to large effect size (measured using the Schedule for Affective Disorders and Schizophrenia for School-Aged Children Present and Lifetime Version – Avoidance; $d=0.70$, $p<0.0001$). The study also found a small to medium difference between groups in relation to hypervigilance, with participants in the intervention group showing significantly greater decreases in hypervigilance (measured using the Schedule for Affective Disorders and Schizophrenia for School-Aged Children Present and Lifetime Version – Hypervigilance; $d=0.40$, $p<0.01$).

2. Anxiety

A meta-analysis conducted by Macdonald et al. (2012 ++) found that cognitive behavioural therapy had a small effect on anxiety in the short term (SMD; -0.23; 95% CI -0.42, -0.03), a small to medium effect in the intermediate term (SMD; -0.38; 95% CI -0.61 to -0.14); and a small effect in the long term (SMD; -0.28; 95% CI -0.52 to -0.04).

3. Depression

A meta-analysis conducted by Macdonald et al. (2012 ++) found that cognitive behavioural therapy had a positive impact on depression with large effect sizes being detected in the short term (mean difference; -1.92; 95% CI -4.24 to 0.40), the intermediate term (mean difference; -1.84; 95% CI -3.41 to -0.27); and the long term (mean difference; -1.19; 95% CI -2.70, 0.32); however these effects were statistically non-significant in the short and long term.

Barbe et al. (2004 -) found that participants randomised to the cognitive behavioural therapy group without a history of sexual abuse had significantly lower rates of major depression at the end of treatment than those in the control group (p=0.02). However, this effect was not observed for those with a history of sexual abuse. In addition, the difference in effect between sexually abused and non-sexually abused individuals was not significant (chi-square =0.64, df=1, p=0.43). Similarly, Shirk et al. (2014 -) found that for female adolescents with depression and a history of abuse there was no difference on changes in depression (measured by Beck Depression Inventory) between a modified CBT intervention and usual care.

4. Behaviour (total scores)

Cohen et al. (1996, reported in Goldman Fraser et al. 2013 +) found that participants randomised to the intervention group showed significantly greater improvements in behaviour (measured using the Child Behaviour Checklist Behavioral Profile – Total) than those randomised to the control group (p<0.01, no effect sizes reported).

Cohen et al. (2004, reported in Goldman Fraser et al. 2013 +) also found a small effect of cognitive behavioural therapy, with participants randomised to the intervention group showing significantly greater improvements in behaviour (measured using the Child Behavior Checklist Total; d=0.33, p<0.01).

Deblinger et al. (2001, reported in Goldman Fraser et al. 2013 +) found that there was no difference between the intervention and control group in changes in behaviour (measured using Child Behaviour Checklist; p-value not reported, non-significant).

5. Internalising and externalising behaviour

Cohen et al. (1996, reported in Goldman Fraser et al. 2013 +) found a significant difference between groups, with participants in the intervention group showing significantly greater improvements in internalising symptoms (measured using the Child Behavior Checklist – Internalising) than those in the intervention group (p>0.002, effect size not presented).

Cohen et al. (2004, reported in Goldman Fraser et al. 2013 +) found that there were no significant differences between groups in level of improvement in internalising problems (measured using the Child Behavior Checklist – Internalising; p=non-significant).

A meta-analysis conducted by Macdonald et al. (2012 ++) found that cognitive behavioural therapy did not have a statistically significant impact on child externalising behaviour, and very small effect sizes were observed, in the short (standardised mean difference; -0.12; 95% CI -0.40 to 0.17), intermediate (standardised mean difference; -0.11; 95% CI -0.42 to 0.21) and long term (standardised mean difference; 0.05; 95% CI -0.16 to 0.27).

6. Social competence

Cohen et al. (1996, reported in Goldman Fraser et al. 2013 +) found no significant difference between groups in level of improvement in social competence (measured using the Child Behaviour Checklist – Social Competence scale; p=not reported, non-significant).

Cohen et al. (2004, reported in Goldman Fraser et al. 2013 +) found no significant difference between groups in level of improvement in improvement in social competence (measured using the Child Behaviour Checklist – Competence; p=not reported, non-significant)

7. Sexualised behaviour

A meta-analysis conducted by Macdonald et al. (2012 ++) found that cognitive behavioural therapy had non-significant impacts on child sexualised behaviour in the short, intermediate and long term. However, effect sizes were medium (mean difference; -0.65; 95% CI -3.53 to 2.24), small to medium (mean difference; -0.46; 95% CI -5.68 to 4.76) and large (mean difference; -1.61; 95% CI -5.72 to 2.49) respectively.

8. Impact on caregiver/parents' health and wellbeing

One study (Cohen et al. 2004, cited in Goldman Fraser et al. 2013 +) found that parents whose children were randomised to the intervention group had significantly better levels of self-reported depression (measured using the Beck Depression Inventory, follow-up point unclear) than parents whose children were randomised to the control group ($d=0.38$, $p<0.05$).

A second study (Deblinger et al. 2001, cited in Goldman Fraser et al. 2013 +) found that mothers of children who were randomised to the intervention group had significantly better levels of maternal distress – intrusive thoughts (measured using the Impact of Events scale, follow-up point unclear) than mothers of children randomised to the control group (d=not reported, $p<0.05$,). However, there were no differences between the intervention and control groups in levels of maternal post-traumatic stress disorder symptoms measured using the Symptom Checklist-90-Revised (d=not reported, p=not reported, non-significant); and maternal distress – avoidant thoughts (measured suing the Impact of events scale, d=not reported, p=not reported, non-significant).

9. Impact on service outcomes

One study (Shirk et al. 2014 -) examined levels of user satisfaction with a modified cognitive behavioural therapy intervention compared to usual care, and found no difference in satisfaction between the 2 groups.

2. Risk reduction through family therapy

Description of evidence

We found 1 moderate quality US study (Danielson et al. 2012 +) which tested the effectiveness of risk reduction through family therapy in reducing substance misuse and mental health problems in young people aged between 13 and 17 who had been sexually abused (see Table 44). We have rated the study as moderate, however the authors note that differences in the intervention and control groups at baseline mean that between-group differences need to be interpreted with caution.

Table 44. Study characteristics – risk reduction through family therapy

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Danielson et al. (2012) (USA)	Moderate	30	Sexually assaulted children between the ages of 13 and 17 (12% were male)	Risk reduction through family therapy	Treatment as usual

Description of intervention

Risk reduction through family therapy is described by its authors as an 'integrated treatment protocol' (p2) which works with the whole family and builds on evidence-based treatments for adolescent substance misuse (multi-systemic therapy), PTSD and depression (trauma-focused CBT) and other risky behaviours. The authors describe the intervention as using 'exposure-based techniques' (p2), drawn from trauma-focused CBT. Other key components of the intervention include:

- ecological theory to give an understanding of the multiple influences on an adolescent's behaviour
- family-based approach to treatment
- strategic family therapy (for example, Haley 1976) to help families to define problems and solve them together.

The intervention is delivered via weekly 60-90 minute sessions, both individually and as a family. In this study the mean treatment length was 23 sessions.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children's health and wellbeing

Danielson et al. (2012 +) conducted mixed-effects regression modelling to assess the impact of intervention condition on outcomes. The study found that at 6-month follow-up young people in the intervention group showed improved outcomes in terms of:

- mental health – in relation to PTSD symptoms (parent-reported, beta=0.87, p=0.004), child depression inventory (beta=0.52, p=0.036) and internalising symptoms (beta=0.53, p=0.008)
- substance misuse over time (beta=0.30, p<0.001)
- family functioning as measured by adolescent-reported cohesion (beta=-1.03, p=0.001) and adolescent-reported conflict (beta=0.92, p=0.001).

No significant differences were reported in relation to:

- adolescent-reported PTSD symptoms or externalising behaviours
- family functioning as measured by parent-report cohesion and conflict
- risky sexual behaviours.

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

Not measured.

3. Psychotherapy (including psychoanalytic/psychodynamic psychotherapy)

Description of evidence

We found 1 moderate quality UK RCT (Carpenter et al. 2016 +) of an intervention developed by the National Society for the Prevention of Cruelty to Children (NSPCC) termed 'Letting the Future In', comparing outcomes with a waitlist control. We found 1 poor quality UK study (Trowell et al. 2002 -) comparing outcomes for sexually abused girls aged 6 to 14 either provided with group-based psychoeducational psychotherapy, or individual psychotherapy. This study was rated as poor due to lack of clarity regarding how analyses were conducted, including the calculation of effect sizes.

We also found 1 relevant good-quality systematic review (Parker and Turner 2013 ++). Studies were eligible for inclusion by Parker and Turner if they were randomised or quasi-randomised trials which compared psychoanalytic or psychodynamic therapy to treatment as usual, waitlist control or no treatment control. For treatment as usual, the authors give treatment by psychiatrist as an example. They also note that studies which compared psychoanalytic/psychodynamic therapy to active comparison groups (such as cognitive behavioural therapy) were excluded. No criteria in relation to publication date were applied. The search for this review returned no eligible results. It should be noted that Trowell et al. (2002 -) was screened for eligibility by Parker and Turner (2013 ++) but was not included for review due to the fact that an active control was used. Carpenter et al. (2016 +) was published after this review was completed, but is likely to have met their criteria.

Table 45. Study characteristics – psychotherapy (including psychoanalytic/psychodynamic psychotherapy)

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Carpenter et al. (2016 +)	Moderate	Children n=242, carers n=165	Children and young people aged 4 to 17 affected by sexual abuse and their non-abusing carer	'Letting the Future In' – a therapeutic intervention which is 'largely psychodynamic' (Carpenter et al. 2016, p10) and 'grounded in an understanding of trauma'. attachment and resilience' (Carpenter et al. 2016:10)	Waitlist

Parker and Turner (2013 ++)	Good	N/A The review did not identify any eligible studies	Studies were eligible if the population included children and adolescents up to the age of 18 who have experienced sexual abuse	Studies were eligible if the intervention being evaluated was psychoanalytic/psychodynamic therapy	Studies were eligible if the comparator was treatment as usual, waitlist control, or no treatment control
Trowell et al. (2002 -)[24] (UK)	Poor	71	Sexually abused girls aged 6 to 14 years	Psychoeducational and psychotherapeutic group treatment, up to 18 sessions	Individual psychoanalytic therapy, for up to 30 sessions
Studies reported in Parker and Turner, 2013 ++ which were relevant to question 16					
N/A The review did not identify any eligible studies					

Description of intervention

Parker and Turner (2013 ++) describe psychoanalytic and psychodynamic psychotherapy as umbrella terms which are often used interchangeably and cover a range of approaches and techniques such as child or adolescent psychotherapy; child analysis or psychoanalysis; Freudian, Jungian or Kleinian therapy; object relations-based therapy; and so on. Despite this variation in usage the authors note that the defining feature of these approaches is the objective of forming a therapeutic relationship and through this exploring (through discussion or play) how earlier events can impact on current behaviours, feelings and relationships. The goal of this process is to enable the individual to become aware of previously 'unconscious' difficulties. The review authors note that psychoanalytic/psychodynamic therapy can be provided both individually or to families or larger groups, and can be of varying intensity with treatment being provided for a few brief sessions, or being delivered over the course of years.

[24] Note – this study was also reported in Goldman Fraser et al. (2013 +) and Leenarts et al. (2013 -). We had originally used data as reported in Goldman Fraser et al. (2013 +) but these appeared to be inaccurate, so full critical appraisal and data extraction of the paper was carried out by the reviewing team.

The ‘Letting the Future In’ intervention (Carpenter et al. 2016 +), while largely psychodynamic, also draws on a wide range of theoretical constructs, including attachment theory, motivational interviewing and elements of trauma-focused CBT. The intervention involves both children and their ‘safe’ carer. Children receive up to 4 therapeutic assessment sessions and 20 intervention sessions, extended to 30 as necessary. Key elements of the intervention with children include use of creative therapies, helping children to be aware of and manage their feelings, providing counselling, work on identity and self-esteem, socio-education and symbolic play. Safe carers are offered up to 8 sessions which include support in dealing with the fact that their child has been sexually abused and preparing them to support their child, including through joint sessions.

There is relatively little detail regarding the interventions provided in the Trowell et al. (2002 -) study. For the group therapy, the study describes the groups as ‘psychoeducational as well as psychotherapeutic’ (p238). Each group was focused on a pre-arranged topic, with notebooks, task sheets and play materials. The study notes that ‘The group also had time to tackle the relationships between the girls and their relationship with the co-therapists, and this was linked to past and current relationships, losses and disruptions’ (p238). For the individual therapy the study states that the early sessions (first 5 sessions) were an engagement phase, the next 15 sessions focused on issues relevant to the particular child and the final 10 focused on separation and ending.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children’s health and wellbeing

1. Impairment of functioning

Carpenter et al.'s (2016 +) analysis was divided into older children and young people (8 and above), who completed the Trauma Symptoms Checklist for Children (TSCC) (Briere 1996) and younger children (under 8) who completed the Trauma Symptoms Checklist for Young Children (TSCYC) (Brier et al. 2001). The primary measures for the study were:

- the proportion of children who had clinical level symptoms or problematic behaviour on 1 or more of the TSCC/TSCYC subscales
- the proportion of children who had clinical or 'significant difficulty' level symptoms or problematic behaviour on 1 or more of the TSCC/TSCYC subscales.

The statistical significance of changes in the proportions of children meeting these criteria was assessed using McNemar's test or Cochran's Q, to accommodate the matched samples.

The study found that:

- For older children, there was a marginally significant reduction at 6 months in the proportion of children with clinical level scores on the TSCC in the intervention group (p=0.065) but not the control group (p=0.839). This was sustained at 12-month follow-up, with the proportion of children who returned to clinical levels of symptoms non-significant (p=0.263).
- For older children there was a significant reduction in the proportion of children with clinical or significant difficulty level scores on the TSCC in the intervention group (p=0.016) but not the waitlist condition (p=1.00). This was sustained at 12-month follow-up, with the proportion of children who returned to clinical levels of symptoms non-significant (p=0.503).
- For younger children, there was no significant reduction in the proportion of children with clinical or significant difficulty level scores on the TSCYC in the intervention group (p=0.625) or control group (p=1.000) at 6 months. Data for this measure were not reported for 12-month follow-up. For 12-month follow up, only data for 'analysis completers' were available which showed a significant decrease between 6 and 12 months in the proportion of children with clinical level scores (p=0.063). However, this analysis is based on data from only 15 children.

Trowell et al. (2002 -) report that both individual and group therapy participants showed improvement in impairment of functioning as measured by the Kiddie Global Assessment Scale (K-GAS) (Chambers et al. 1985) at 12-month and 24-month follow-ups. It is unclear if the improvement over time is statistically significant. There were no significant differences between individual and group psychotherapy conditions (effect sizes not reported, but identified as d<0.5 by study authors).

In the sample as a whole, there was a significant shift from major/serious categories of impairment to less severe impairment (effect sizes not reported). The authors also report a significant reduction in psychopathology in relation to general anxiety, depression and separation anxiety. Between-groups analyses do not appear to have been conducted for these outcome measures.

2. Post-traumatic stress disorder – re-experiencing

Trowell et al. (2002 -) report that both individual and group therapy participants showed improvement in the re-experiencing of traumatic events. The extent of improvement was greater in the individual therapy group at 1 year, with medium effect size (d=0.60) and 2 years, with medium to large effect size (d=0.79).

3. Post-traumatic stress disorder – persistent avoidance

Trowell et al. (2002 -) report that both individual and group therapy participants showed improvement in the re-experiencing of traumatic events. The extent of improvement was greater in the individual therapy group at 1 year, with medium to large effect size (d=0.66) and 2 years, with small to medium effect size (d=0.36).

Impact on caregiver/parents' health and wellbeing

Carpenter et al. (2016 +) found that, of parents who completed relevant assessments, there was little change in proportions of parents with clinical level Parenting Stress scores from baseline to 6 months. At 1 year follow-up, significant improvements in 'total stress' were observed for both the intervention (p=0.016) and control groups (p=0.021). No significant differences were found for other subscales.

Impact on service outcomes

Not measured.

4. Prolonged exposure therapy

Description of evidence

We identified 1 good-quality US RCT examining the effectiveness of prolonged exposure therapy (Foa et al. 2013 ++) in treating young women (aged 13-18) who had experienced sexual abuse (see Table 46).

Table 46. Study characteristics – prolonged exposure therapy

Study	Quality rating	n	Population	Intervention	Comparison group(s)
Foa et al. (2013 ++)	Good	61	Female adolescents (13-18 years) with a primary diagnosis of chronic or subthreshold post-traumatic stress disorder resulting from experience of sexual abuse	Prolonged exposure therapy	Supportive counselling

Description of intervention

The intervention is described as a modified version of prolonged exposure therapy (usually provided to adults) which has been adapted for use with adolescents. Treatment includes 'in vivo' exposure (confronting trauma reminders in real life) and 'imaginal exposure' (revisiting and recounting the traumatic memory). It is unclear, in the context of sexual abuse, what either in vivo or imaginal exposure comprise.

The programme is comprised of 8 modules delivered in up to 14 weekly 60- to 90-minute sessions. Progress through modules is determined according to the needs and abilities of each participant.

Young women in the comparison group received supportive counselling which is described as a client centred therapy based on the Traumagenic Dynamics Model (Finkelhor and Browne 1985) and the Rogerian psychotherapy model (Rogers 1951). The aim is to establish a therapeutic relationship which is empowering, trusting and validating, and participants decide '… when, how, and whether or not to address their trauma' (p2652), although at sessions 4 and 8, counsellors ask participants to talk about their feelings regarding their trauma.

Participants in both the intervention and control groups also received up to 3 preparatory sessions focusing on case management issues such as level of parental

involvement, safety concerns (participants assessed as being actively suicidal were excluded), desire for treatment, etc.

Both the intervention and the control treatment were delivered by counsellors educated to masters level working at a rape crisis centre.

Narrative summary

Impact on incidence of abuse and neglect

Not measured.

Impact on risk of abuse and neglect

Not measured.

Impact on quality of parenting and parent-child relationships

Not measured.

Impact on children's health and wellbeing

1. Interviewer-rated post-traumatic stress disorder symptom severity

Between baseline and post-treatment, both groups showed significant improvements in interviewer-rated post-traumatic stress disorder symptom severity (measured using the Child PTSD Symptom Scale – Interview), with large effect sizes (intervention d=2.72, p<.001; control d=1.71, p<.001); however the intervention group showed a significantly greater improvement than the comparison group, with a large effect size (d=1.01, p<.001). Between post-treatment and 12-month follow-up, neither group showed significant improvements in symptom severity (intervention p>.88; control p>.88, effect sizes not reported) and the between-group difference in symptom severity was also non-significant (p>.89, effect size not reported). Between baseline and 12-month follow-up both groups showed significant improvements in symptom severity, with large effect sizes (intervention d=2.67, p<.001; control d=1.87, p<.001), however the intervention group showed a significantly greater improvement than the comparison group, with a large effect size (d=0.81, p<.02).

At both post-treatment (p=.001) and 12-month follow-up (p=.02) significantly more participants in the intervention group were classed as 'good responders' to treatment (score of ≤8 on the Child PTSD Symptom Scale – Interview) than those in the

comparison group. The proportion of participants who were classed as good responders at post-treatment who maintained this score at 12-month follow-up did not differ significantly by group (p=.53).

2. Rates of post-traumatic stress disorder diagnosis

Between baseline and post-treatment, both groups showed significant decreases in rates of diagnosis of post-traumatic stress disorder (measured using the post-traumatic stress disorder module of the DSM-IV Schedule for Affective Disorders and Schizophrenia for School-Age Children; intervention p<.001; control p<.001, effect sizes not reported), however the intervention group showed a significantly greater decrease in rate of diagnosis than the comparison group (p<.01, effect size not reported). Between post-treatment and 12-month follow-up neither group showed significant decreases in rate of diagnosis (intervention p>.19; control p>.19, effect sizes not reported) and the between-group difference in rate of diagnosis was also non-significant (p>.57, effect size not reported). Between baseline and 12-month follow-up both groups showed significant decreases in rates of diagnosis (intervention p≤.001; control p≤.001, effect sizes not reported), however the intervention group showed a significantly greater decrease in rate of diagnosis than the comparison group (p=.01).

3. Self-reported post-traumatic stress disorder symptom severity

Between baseline and post-treatment, both groups showed significant improvements in self-reported post-traumatic stress disorder symptom severity (measured using the Child PTSD Symptom Scale – Interview (intervention p<.001; control p<.001, effect sizes not reported); however the intervention group showed a significantly greater improvement than the comparison group (p=.02, effect size not reported). Between post-treatment and 12-month follow-up neither group showed significant improvements in symptom severity (intervention p>.19; control p>.19, effect sizes not reported) and the between-group difference in improvements was also non-significant (p>.57, effect size not reported). Between baseline and 12-month follow-up both groups showed significant improvements in symptom severity (intervention p≤.001; control p≤.001, effect sizes not reported); however the intervention group

showed a significantly greater improvement than the comparison group (p=.02, effect size not reported).

4. Self-reported depression severity

Between baseline and post-treatment, both groups showed significant improvements in self-reported depression symptom severity (measured using the Children's Depression Inventory; intervention p<.001; control p<.001, effect sizes not reported); however the intervention group showed a significantly greater improvement than the comparison group (p=.008, effect sizes are not reported). Between post-treatment and 12-month follow-up neither group showed significant improvements in symptom severity (intervention p>.19; control p>.19, effect sizes not reported) and the between-group difference in improvements was also non-significant (p>.57, effect size not reported). Between baseline and 12-month follow-up both groups showed significant improvements in symptom severity (intervention p≤.001; control p≤.001, effect sizes not reported); however the intervention group showed a significantly greater improvement than the comparison group (p=.02, effect sizes not reported).

5. Interviewer-rated functioning

Between baseline and post-treatment, both groups showed significant improvements in interviewer-rated functioning (measured using the Children's Global Assessment Scale; intervention p<.001; control p<.003, effect sizes not reported); however the intervention group showed a significantly greater improvement than the comparison group (p=.008, effect size not reported). Between post-treatment and 12-month follow-up neither group showed significant improvements in functioning (intervention p>.19; control p>.19, effect sizes not reported); and the between-group difference in improvements was also non-significant (p>.57, effect size not reported). Between baseline and 12-month follow-up both groups showed significant improvements in interviewer-rated functioning (intervention p≤.001; control p≤.001, effect sizes not reported); however the intervention group showed a significantly greater improvement than the comparison group (p=.01, effect size not reported).

Impact on caregiver/parents' health and wellbeing

Not measured.

Impact on service outcomes

Not measured.

Economics

Notes to assist in interpreting economic evidence

It is important to note that cost-effectiveness results from non-UK studies will have limited applicability to inform UK practice. This is due to differences in the unit costs of services and differences in the institutional context and corresponding patterns of service use. The implication is that the monetary results from non-UK studies do not provide conclusive evidence but they can provide an indication about cost-effectiveness for the UK context. In order to be conclusive about cost-effectiveness results, non-UK research would need to be replicated in the UK.

Summary of economic evidence – question 15

Only 2 economic evaluations were identified, 1 was from the UK, evaluating the impact of a parenting intervention aimed at caregivers of adoptive children. The second RCT was from the USA, evaluating the impact of 2 different assessment approaches in responding to families referred to child protective services and considered to be low-to-moderate risk.

1. UK RCT

One small sample, pragmatic RCT (n=37) from the UK evaluated the impact of a parenting intervention aimed at caregivers of non-relative adoptive children within the first 18 months of placement (Rushton et al. 2010 -). The aim of the intervention is to improve caregivers' parenting skills and parenting sense of competence. Caregivers were eligible if children were between ages 3 to 8 years and were screened as having serious behavioural problems as identified by the parent (greater than 13 on the Strengths and Difficulties Questionnaire, SDQ) or social worker (greater than 11 on the SDQ).

The evaluation is a 3-arm RCT comparing 2 intervention arms to 'usual care'. The first intervention arm uses an adaptive cognitive behavioural approach aimed at 'increasing acceptable behaviour by using praise and rewards, to ignore unacceptable behaviour, by setting firm limits and by using logical consequences

and problem-solving' and places 'greater emphasis on the need for adopters to conduct daily play sessions with their child and in helping them when their child rejects their praise and/or their rewards' (Rushton et al. 2010, pp531-2). The second intervention arm uses an educational approach to help parents to understand the meaning and origins of the child's behaviour and help parents anticipate events and increase their ability to manage the behaviour.

The quality of the study design was rated poorly (-) for internal validity. This is because the study combined the results of the 2 active intervention arms because of their small sample sizes. It is unclear whether it was appropriate to do so given the different nature of the interventions and the corresponding difficulty in interpreting the findings.

The aims of the intervention were to improve parenting and reduce child behaviour problems. Secondary outcomes included child-oriented outcomes, including the Expression of Feelings Questionnaire, Post Placement Problems, and the visual analogue scale to measure emotional distress, misbehaviour and attachment (this was measured at follow-up only, not measured at baseline or end of intervention). Secondary parent outcomes included daily hassles and satisfaction with parenting advice (only measured at post-intervention).

The economic evaluation was comprehensive and measured health, social services and education services based on self-report data using the Client Service Receipt Inventory. Costs and outcomes were measured from the period prior to baseline (at adoptive placement) until post-treatment (3 months) and 6-month follow-up.

The evaluation found that the combined intervention groups were not cost-effective for the primary child outcome using the SDQ and for all other secondary outcomes. However, the combined intervention groups were more cost-effective than the usual care service for the primary outcome of parent sense of competence when measured at post-treatment and at 6-month follow-up.

The study does not disaggregate total costs into their respective components (intervention costs vs service use). Total costs, from the perspective of health, social services and education, were higher for the intervention group, but not statistically

different than the control group at either post-treatment (£1,528 higher) or at 6-month follow-up (£1,652 higher).

In summary, these findings have very limited applicability to the UK context given the weak study design.

2. US RCT

One large RCT (n=5391) from the USA evaluated the impact of 2 different assessment approaches in responding to families referred to child protective services who are considered low-to-moderate risk (Winokur et al 2015 +). Exclusion criteria were 'families with allegations of serious harm, sexual abuse, and suspicious child fatality' (Winokur et al 2015 +, p100). The time horizon of the analysis was 15 months, which included 12 months of follow-up post-intervention.

The study aims to determine whether families assigned to the 'Family Assessment Response' (FAR) track (n=1963) are safe or safer than families assigned to the 'Investigation Response' (IR) track (n=3428). The FAR track is a 'comprehensive assessment of the family's strengths and needs instead of an immediate maltreatment determination'. The IR track is a 'maltreatment determination with possible provision of services after opening a traditional child welfare case'. The evaluation also took place during a time of system-wide changes and new organisational structuring.

The primary outcome is safety, defined as both (a) percentage of families and (b) time to event (survival analysis). The primary outcomes include: 1) referral within 365 days of initial referral; 2) assessment within 365 days of initial referral; 3) high-risk assessment (HRA) within 365 days of initial referral; 4) founded HRA within 365 days of initial referral; 5) traditional child welfare (CW) case opened after initial involvement; and 6) out of home (OOH) placement after initial involvement.

The analysis only collected case-level costs accruing to child protective services, including 1) assessment and subsequent processes (of the caseworker only), and 2) any services provided to the family as a result of being involved with CWS. There are a few limitations in the cost analysis. The authors do not include costs of services provided outside child protective services system funding but assume that these costs would not be different between groups (Winokur et al. 2015 +, p104). The

costs of the intervention were estimated using average caseworker contacts with families. They do not include associated administration, which might lead to biased estimates of intervention costs. A full-cost approach was not used in the estimation of unit costs. Unit costs were based on local data and considered salary and benefits to calculate the hourly cost of the intervention caseworker. In conclusion, intervention costs are potentially biased and underestimated.

Over a 15-month period there were no differences in the primary outcomes between the 2 groups. The comparison group did better in terms of having a high-risk assessment completed sooner than the intervention group. However, this did not lead to any material differences in child wellbeing, given that there were no differences in out-of-home placements. In terms of costs, there were no differences in overall mean costs between groups: intervention, $1,212 vs control, $954, p=0.611 (confidence intervals and standard deviation were not reported). Costs were categorised as 'initial' and 'follow-up' costs. While costs were not different between groups, the authors report that follow-up costs were significantly higher than the intervention group. The authors think that a longer-follow up period would be useful to assess whether this difference would be sustained and, if so, may change the findings regarding cost-effectiveness.

In conclusion, we cannot say which whether the FAR or IR tracks are more or less cost-effective in the UK context.

De novo economic modelling, parenting intervention for foster carers

Introduction

The Guideline Committee were interested in conducting new economic analysis on a parenting intervention aimed at foster carers with the aim of increasing the proportion of positive parenting strategies relative to discipline used (expressed as a ratio) and reducing parent-reported child behaviour problems.

Our analysis is based on the evaluation of the intervention, 'Keeping Foster and Kinship Carers Trained and Supported' (KEEP). This is a 90-minute group-based intervention provided on a weekly basis for 16 weeks. In the evaluation, the KEEP intervention is compared to standard caseworker services for foster care.

The evaluation includes children in both early and later stages of their foster care career (that is, those with their first placement or who have had multiple foster care placements) and children who had been in their current placement for a minimum of 90 days and are not 'medically fragile'. The intervention targets longer-term foster placements so it excludes children who were in emergency foster care placements and temporary shelters. The majority of foster carers were experienced. Foster carers with their own biological children or who were looking after other foster children in their home were also considered eligible and could be included in the study. Foster care placements included both kin and non-kinship arrangements.

This RCT was conducted in the USA with a moderate sized sample (baseline, n=700, follow-up, n=564, 80.6% retention) (Chamberlain et al. 2008; Price et al. 2008). The study was identified in a good quality systematic review and was rated as being of moderate quality (Goldman Fraser et al. 2013 +). The systematic review did not provide further detail to explain the rating.

Methods

We undertook a cost-effectiveness analysis for both the outcomes of improvement in positive parenting relative to discipline used (expressed as a ratio) and the reduction in foster carer-reported child behaviour problems. Our analysis only includes intervention costs. We do not make assumptions about the effect of the intervention on public sector service use or about the impact on QALYs, as this information was not available. The time horizon of the economic analysis is the same as in the evaluation: a 5.5-month period for outcomes and a 16-week period for costs.

Intervention effects

The KEEP intervention led to a mean reduction of 1.22 foster carer-reported child behaviour problems, as measured by the Parent Daily Report checklist (PDR, Chamberlain and Reid 1987). It asks the foster carer to recall the child's behaviour in the past 24 hours and to answer whether certain types of behaviour occurred. The measure lists 30 different behaviour problems. Baseline and final assessment scores were averaged from 3 telephone interviews (Chamberlain et al. 2008, p6). The KEEP intervention also led to an increase of 0.07 in the ratio of positive reinforcement strategies relative to discipline used. The authors use a 'multi-method index' to

compute this ratio based on a list of questions developed by the study authors. Both improvements are considered to be small (d=0.26 and d=0.29, respectively)

Intervention costs

The KEEP intervention was delivered in groups of 3 to 10 foster carers led by a trained facilitator and co-facilitator who are both paraprofessionals. The intervention is manualised and comprises 16 sessions delivered on a weekly basis lasting for 90 minutes (Chamberlain et al. 2008). Childcare and refreshments were provided at each session. Home visits were delivered when sessions were missed, which occurred in 20% of total sessions (Price et al. 2008, p6). Paraprofessional training lasted for 5 days and there was weekly supervision to review and discuss videotaped sessions (Price et al. 2008, p6). Foster carers were also paid $15 per session attended. For the US, this represents a payment that is approximately 1.5 times the minimum wage (varies state to state). Our costing approach estimates an approximate English-equivalent of £16.20 per session (twice the national minimum wage applicable at time of writing of £7.20/hour), equating to £210.60 per foster carer, assuming they attend 13 of 16 sessions.

The 2 major factors that influence the cost of the intervention are group size (we provide estimates for sizes of 3, 6 and 10) and the type of professional who acts as the facilitator and co-facilitator (we provide estimates for both family support workers and for children's social workers, who are more costly). We also include the costs of recruitment and additional intervention components (childcare, refreshments, venue hire, materials). We included the cost of travel for both facilitators, which we assumed to be 1 hour of travel for each session, for each facilitator. Taken together, our intervention cost estimates range from a low of £2,012 per foster carer (delivered by a family support worker for a group size of 10) and can be as high as £9,818 per foster carer (delivered by a child social worker for a group size of 3).

Cost-effectiveness results

To calculate the mean cost-effectiveness ratios, we undertook probabilistic sensitivity analysis, which addresses sampling uncertainty in relation to the effectiveness parameters. We undertook scenario analysis in relation to intervention costs because intervention costs are fixed and are not probabilistic. The scenario analysis on costs considers the lower and upper intervention cost estimates. The results of

the simulation, for the lower and upper intervention cost scenarios, indicate that the KEEP intervention was able to reduce child behaviour problems and the mean cost for a 1-unit reduction in child behaviour problems is between £1,583 and £8,429. Likewise, the KEEP intervention was able to improve the amount of positive parenting used relative to the amount of discipline used (expressed as a ratio) and the mean cost for a 1-unit improvement in this ratio is between £28,777 and £140,379. Unfortunately it was not possible to convert changes in these outcomes into quality adjusted life years (QALYs). If we had been able to, then we could benchmark it to NICE's suggested level of cost-effectiveness, which is equal to or below £20-£30,000 per QALY.

In conclusion, our analysis quantifies the costs of the intervention relative to the short-term impacts on improvements in parenting skills and on reducing child behaviour problems.

Discussion

In conclusion, there is not enough evidence to assess the cost-effectiveness of the KEEP intervention, given the lack of evidence to make links between reported outcomes and impact on QALYs or public sector costs.

We undertook additional reviews of the literature to understand whether there might be other costs and benefits that were not captured in this US study. Our additional analysis indicates that there is likely to be additional benefits to the child and some reduced costs to the public sector in the short, medium and long term.

In the short term, some of the intervention costs might be offset by preventing a foster placement disruption (change in foster carers) or the costs of a child running away. The US study found that children with 7 or more foster carer-reported child behaviour problems per day had a higher chance of a placement disruption. In particular, each additional behaviour problem above 6 had an additional 1.2 higher chance of a placement disruption (Chamberlain 2006). For example, a child with 10 foster carer-reported child behaviour problems per day would have 2.07 times higher chance of a placement disruption than a child with 6 and fewer behaviour problems (calculated as 1.2^4).

Evidence from this US study is also supported by evidence from 1 meta-analysis of unclear quality (Oosterman et al. 2007, p67). The meta-analysis finds that the association between child behaviour on foster placement disruption range from small (r=0.22 to 0.28) to moderate (r=0.51). The size of the effect depends on whether univariate or multivariate statistical analyses were used, with multivariate analyses showing smaller effects. These findings are also supported by another systematic review, but these results are summarised narratively and do not use a meta-analysis (Rock et al. 2013).

This finding is important because foster placement disruptions is costly. We could not find studies that calculated the societal or public sector costs of a foster placement disruption. However, we did identify the costs to children's social care services. Estimated administrative costs to children's social care services are between £2,150 and £2,700, depending on whether the child is placed through the local authority or using an independent foster care agency (Curtis 2016, pp94, 130). Costs might be higher if an initial foster placement disruption results in a second placement. For example, an emergency placement followed by a longer-term placement. However, we could not find data on the probability of having 1 or 2 subsequent placements. Furthermore, there is likely to be additional administrative costs to health, social care, and education services if subsequent placements were made out-of-area (Ward et al. 2009, p1117). National data indicate that 37% of new placements are made outside the council boundary and 5% are made 20+ miles away from inside council boundary (Department for Education 2016, Tab A7, B3).

In the medium to long term, there is evidence from the same meta-analysis that the number of previous out-of-home placements is associated with an increased likelihood of future foster placement disruptions (small effect, r=0.12, based on 5 studies, $p<0.001$) (Oosterman et al. 2007, p66). Indeed, the US study found that the KEEP intervention had a preventive effect which reduced the risk of foster placement disruptions among a subgroup of children who had a greater number of prior placements. In particular, the KEEP intervention reduced the risk of a placement disruption by 12% among those children with a greater number of previous placement disruptions (Price et al. 2008, Table 3, p18). This means potential cost-

savings in the medium to long term, as the KEEP intervention reduces the risk of future placement disruptions among those with a history of placement moves.

One research expert believes that the largest cost savings would occur in the long-term if the intervention results in foster children becoming more settled in long-term foster care and continue to stay through their adolescence. This is opposed to a trajectory where the child has difficulties in their foster placement and eventually moves into residential care, which is more costly than foster care services (Ian Sinclair, personal communication, April 2016). Residential homes for children cost between £2,900 and £3,170 per week, which is about 4 to 5 times higher than the cost of foster care placement, which is £614 per week (Curtis 2015, pp84-6).

In relation to the wellbeing impacts on the child, there are likely to be positive effects on child wellbeing as a result of preventing a foster placement move. Our search of the literature did not identify any English studies but we did find 3 US studies that found a causal link between foster placement moves and a subsequent negative impact on child wellbeing. These 3 US studies are important because they were designed to assess causality and so this evidence is stronger than the many studies available that only measure association (Aarons et al. 2010; Newton et al. 2000; Rubin et al 2007). In each study the child's wellbeing was measured using the Child Behaviour Checklist (CBCL). The CBCL is composed of 3 components: internalising and externalising behaviour problems and total behaviour problems. After controlling for initial baseline characteristics, including child behaviour, a child has a subsequently greater number of child behaviour problems as a result of placement instability and as a result of a large number of placement changes.

In summary, the additional research identified suggests that it is possible for there to be reduced costs to the public sector in the short, medium, and long term and that there are also benefits to the child in preventing subsequent harm to their wellbeing.

Results from the US study indicate that greater preventative effects are more likely among children with greater numbers of foster carer-reported child behaviour problems and for children with a higher number of previous foster placements. While we were unable to provide specific estimates of cost-effectiveness for these

subgroups, it may be more cost-effective to prioritise these foster carers if there aren't enough resources to provide the KEEP intervention to everyone.

However, we must emphasize that without a robust economic evaluation, we cannot be sure whether or not the intervention is cost-effective, based on currently available evidence.

It is also important to note that we have extrapolated our findings on effectiveness from US data, as no UK evidence meeting our criteria was identified.

The full economic report is available in Economic Appendix C.3.

De novo economic modelling, home visiting and parenting intervention for maltreating parents and their biological children

The Guideline Committee was interested in conducting new analysis on a home visiting and parenting intervention aimed at maltreating parents and their biological children aged up to 12 years.

We undertook a cost-effectiveness analysis based on the results of a US RCT evaluating the impact of the 'SafeCare' intervention. SafeCare is a home visiting intervention provided on a weekly basis for 6 months with sessions lasting between 60 to 90 minutes. Two types of SafeCare were trialled, coached and un-coached. In the coached version of SafeCare, the coach accompanies the home visitor on a monthly basis and provides help with logistics (it is not meant to improve home visitor fidelity to the SafeCare model). The US study does not describe who provides home visiting or who provides coaching, but states that they have minimum workforce qualifications. We assumed that a potential home visitor in the UK could be a family support worker, health visitor or children's social worker.

The intervention is compared to 2 active comparison groups, in particular, coached and uncoached home visiting. The comparison groups are identical to SafeCare in relation to the intensity (60-90 minutes per visit) and duration (6 months) of home visiting. The difference between them is the SafeCare approach. In both intervention and comparison groups, home visitors have caseloads between 17 and 18 families.

This US evaluation was based on a large sample RCT (n=2175) and was conducted between 2003 and 2006 (Chamberlain et al. 2006, 2008). Treatment completion rates were high, 89% and 87% for intervention and comparison groups respectively. This study was identified in a moderate quality systematic review (Goldman Fraser et al. 2013 +). It rated the US study as being of moderate quality. The rationale for the rating is not provided.

Methods

The aim of this report is to undertake a cost-effectiveness analysis of the SafeCare intervention compared to the active comparison group. Our analysis only estimates the intervention costs. We do not make assumptions about the impact of the intervention on QALYs or on public sector costs due to a lack of data on the key causal links from the study's reported outcomes. The time horizon of the economic analysis is the same as in the US study: intervention costs accrue over a 6-month period but the outcomes are measured over a 6-year time horizon.

The cost-effectiveness analysis presents results for the outcome of the risk reduction in the rates of re-report to child protective services. Ideally, we would have liked to approximate the findings to the UK context by estimating the potential numbers of re-reports avoided. However, to do this, we would need English baseline data on the rates of re-reports to child protective services for maltreating parents with children aged between 2 to 12 years. When English rates are multiplied by the risk reduction found in the US study, we are then able to approximate the reduction in numbers of re-reports to child protective services. It is necessary to use English data rather than US data because re-reports to child protective services across countries are not the same. However, we could not find English data that matched our requirements, and so we could only present the results as the relative risk reduction, as reported in the US study.

We also explored the possibility of modelling the additional impacts on QALYs and public sector costs associated with a reduction in re-reports to child protective services. We were unable to do so because this requires us to make assumptions about what happens to the child after the report. The results from the US study do not distinguish between reports that are confirmed and unconfirmed. Therefore, any modelling using the study's reported outcome would introduce too much uncertainty.

Intervention effectiveness

The authors of the US study presented the results by pooling the effect of the coached and uncoached SafeCare interventions compared to the coached and uncoached comparison group. This means they did not provide separate results for coached and un-coached versions of SafeCare versus coached and un-coached comparison services. The results of the analysis are presented using two different statistical approaches. In the first approach, SafeCare results in a statistically significant reduction in reports to child protective services by 17% (hazard ratio = 0.83, 95% CI=0.70 to 0.98). The second statistical approach has similar results (17% reduction) but a smaller confidence interval (hazard ratio = 0.83, 95% CI=0.75 to 0.93). In our analysis, we use the results with the larger confidence interval to keep our estimates of cost-effectiveness conservative. Most importantly, the effects of SafeCare are sustained beyond the 6-month period of the intervention. There was a sustained reduction in reports to child protective services in the next 5.5 years.

Intervention costs

Our analysis only includes intervention costs. As the study only presents the pooled effects for coached and un-coached interventions, this presents some challenges regarding whether to recommend the coached and un-coached SafeCare interventions. For our cost-effectiveness analysis, we use the average cost of the coached and un-coached intervention. The range of intervention cost estimates, delivered over a 6-month period, is between £3,500 and £6,000 per family. The cost of the intervention is influenced by several factors.

First, the study does not describe who provides home visiting but states that they have minimum workforce qualifications. We assumed that a potential home visitor in England could be a family support worker, health visitor or children's social worker. We selected these professionals to illustrate the range of effect on intervention costs. Respectively, the hourly unit costs for each are £45.00, £76.00, and £85.50; this includes an additional 30 minutes of administrative family-related work (so we assumed). Second, we assumed that coaching and training was provided by a children's social worker – the rationale was to provide a conservative estimates of intervention cost. In practice, however, anyone who is qualified to deliver training is eligible, and could also be a family support worker or health visitor, therefore,

lowering the cost of the intervention. These 3 assumptions about who delivers the intervention are the main factors that influence the range of intervention cost estimates.

We also make additional assumptions, which influence the cost of the intervention. The authors of the US study report that home visits occur weekly and last between 60 to 90 minutes, our cost estimates assume an average visit of 75 minutes. Our cost estimates also include the costs of travel, which we assumed to be 1 hour for each home visit. We also include the costs of training. Group training is provided to 3 to 4 home visitors, for 5 days, and we have assumed a day's training lasts 8 hours per day and assumes it is delivered to a group of 3 professionals. We also include the costs of the home visitor receiving 9 directly observed field sessions as a part of training, and we assume this lasts an average of 75 minutes.

Cost-effectiveness results

To calculate the mean cost-effectiveness ratios, we undertook probabilistic sensitivity analysis, which addresses sampling uncertainty in relation to the effectiveness parameters. We undertook scenario analysis in relation to intervention costs because intervention costs are fixed and are not probabilistic. The scenario analysis on costs considers the lower and upper intervention cost estimates. The results of the simulation, for the lower and upper intervention cost scenarios, indicate that the mean cost-effectiveness ratios are £286 and £490, respectively, for a 1% reduction in reports to child protective services.

Unfortunately it was not possible to convert changes in the outcome of re-reports into QALYs. If we had been able to, then we could benchmark the results of this analysis to NICE's suggested level of cost-effectiveness, which is equal to or below £20-£30,000 per QALY.

In conclusion, our analysis quantifies the costs of the intervention relative to the long-term impacts on reductions in re-reports to child protective services.

Discussion

In conclusion, there is not enough evidence to assess the cost-effectiveness of the SafeCare intervention, given the lack of evidence to make links between reported outcomes and impact on QALYs or public sector costs.

This analysis was only able to estimate the English-equivalent costs of the intervention per family, assuming the average cost of the coached and not coached versions. Three different cost scenarios were presented to reflect the different types of professionals who could potentially deliver the intervention (family support worker, health visitor, child social worker). Across each of the scenarios the cost per family for 6 months of home visiting is between £3,500 and £6,000. The US study found that the intervention led to an average 17% risk reduction (95% CI, 2% to 30%) over a 6-year period in reports to child protective services.

The results of the SafeCare intervention were presented as a pooled effect of coached and un-coached home visiting. The purpose of coaching is to help home visitors resolve logistical issues and was not used as a tool to increase fidelity to the SafeCare intervention. We could not present separate effectiveness results for the coached and un-coached intervention arms as these were not provided by the study authors.

This presents some challenges around making recommendations and the interpretation of the cost-effectiveness analysis. Given that we presented an average cost of coached and not coached SafeCare intervention, in the worst-case scenario, we may have slightly overestimated the intervention's cost-effectiveness if we only consider intervention costs. The additional cost of coaching is £1,100 per person, meaning that, if the coached intervention were provided, we have overestimated cost-effectiveness by £550.

The full economic report is available in Economic Appendix C.3.

Summary of economic evidence – question 16

Notes to assist in interpreting economic evidence

It is important to note that cost-effectiveness results from non-UK studies will have limited applicability to inform UK practice. This is due to differences in the unit costs of services and differences in the institutional context and corresponding patterns of service use. The implication is that the monetary results from non-UK studies do not provide conclusive evidence but they can provide an indication about cost-effectiveness for the UK context. In order to be conclusive about cost-effectiveness results, non-UK research would need to be replicated in the UK.

Summary of economic evidence

Three economic evaluations were identified, of which 2 were UK RCTs focusing on sexually abused girls or sexually abused children. The third is an economic decision model based on the Australian context and focused on the treatment of post-traumatic stress disorder among sexually abused children. We also undertook 1 new economic analysis on trauma-focused cognitive behavioural therapy for children who have been sexually abused.

1. UK RCTs

One UK economic evaluation is a moderate sized pragmatic RCT (n=242) focusing on sexually abused children, most of whom were girls (75%) (Carpenter et al. 2016 +). Sample participants were aged between 6 and 16 years. It compares individual psychodynamic therapy vs a 6-month waitlist control group. Carers in the intervention group also received individual counselling, awareness and management of feelings and socio-educative work; but in reality only 40% of carers received this.

The study measures the impact on the primary outcome of participants' symptoms. This was measured by 'the change in the proportion of children with clinical levels of symptoms' and 'the proportion of children with significant difficulties' (as measured by the Trauma Symptoms Checklist). The secondary outcome was the proportion of parents with clinical levels of stress (as measured by the Parenting Stress Index). Changes in participants' outcomes are measured at post-treatment (6 months) and 12 months.

The economic evaluation is limited because it only measures intervention costs. The intervention costs an additional £2,298 per child (price year not reported), for an average of 22 sessions. The study does not report on participants' use of wider health and social care services. The authors report that these will be provided in a separate report but we could not identify this report.

The evaluation finds that, for the whole sample of young and older children, the intervention has mixed cost-effectiveness over the short term (6 months follow-up). For the outcome of 'one or more significant difficulties' the intervention was cost-effective: the intervention led to a greater improvement in significant difficulties compared to waitlist control. For the outcome of clinical thresholds, the intervention

may not be cost-effective: the intervention was trending toward a greater improvement but this was not statistically significant.

For the subgroup comprising just young children, the intervention is not cost-effective in the short term (6 months follow-up) for the combined outcome of the percentage of children with ‘clinical levels of symptoms’ and ‘one or more significant difficulties’. Said another way, the intervention cost more but did not lead to any improvements.

The authors measure the change in the intervention’s outcomes for an additional 6 months, measured as the change from 6-month follow-up to 12-month follow-up. However, these results cannot be used in determining the intervention’s cost-effectiveness because they cannot be compared to the control group. This is because the waitlist control group started to receive the intervention at the end of the 6-month follow-up period. Further research is needed to understand whether effects found at 6 months are sustained.

One small UK RCT (n=72) compares individual psychoanalytical therapy to group psychotherapy for sexually abused girls aged between 6 and 14 years (McCrone et al. 2005 -). Participants’ baseline diagnoses include post-traumatic stress disorder (73%), major depressive disorder (57%), separation anxiety (58%) and general anxiety disorder (37%).

The individual therapy provides a maximum of 30 sessions and group therapy provides up to 18 sessions with a group size of 5 similarly aged girls. Carers in both groups were provided with support from social workers, in either individual or group sessions with a varied number of sessions. The purpose of support was to ensure girls’ attendance at treatment, to help carers understand the girls’ difficulties and to support carers’ own needs.

The study design was rated (-). The study evaluates outcomes and costs over a 2-year period. Outcomes included symptoms of post-traumatic stress disorder (as measured by Orvaschel’s scales) and global functioning (as measured by the Kiddie-GAS – Global Assessment Scale). The analysis only includes the cost of the intervention and does not measure changes in health and social care service use.

Individual psychoanalytic therapy was more effective for the outcomes of post-traumatic stress disorder for the subscales of re-experiencing and persistent avoidance at 12 and 24 months follow-up (as measured by Orvaschel instrument). For these outcomes, individual psychoanalytic therapy is cost-effective. For the post-traumatic stress disorder subscale of increased arousal, there were no differences between groups and so the individual therapy is not cost-effective. For the outcome of impairment, as measured by the using the Kiddie Global Assessment Scale, there were no differences between groups, so the intervention is not cost-effective.

The evaluation finds that the intervention has mixed cost-effectiveness. The individual therapy intervention costs £1,246 more than the group-based psychotherapy. The mean cost of individual therapy is £3,195 per person compared to £1,949 per person receiving group therapy. Costs reflect the 1999 price year.

2. Australian economic decision model

One Australian economic decision model was identified but is not directly applicable to the UK context (Gospodarevskaya et al. 2012).[25] The economic model would need to be adapted to reflect UK unit costs and clinical data.

The 4-arm decision model compares trauma-focused cognitive behavioural therapy (T-CBT) vs T-CBT + pharmacotherapy (SSRI) vs non-directive supportive counseling vs no treatment.

The modelling study is based on a 12-month decision tree which examines the effectiveness of various treatments on the proportion of participants falling into 3 categories of diagnoses: 1) post-traumatic stress disorder; 2) post-traumatic stress disorder + depression; and (3) no post-traumatic stress disorder + no depression. The results of the 12-month decision tree are then extended to a 30-year Markov model to measure the impact on quality of life, as measured by the percentage of individuals remaining in those 3 categories and includes additional categories of 'suicide' and 'death – non suicidal causes'. The data used for the Markov model are based on a mix of Australian and US data. The model also makes some assumptions, including assuming that the differences in treatment effects for the entire 30-year period are sustained based on findings at 12-month follow-up. The

[25] Note this study was not critically appraised as it is a decision model rather than an empirical study.

model also assumes that there is no relapse in post-traumatic stress disorder but that relapse into depression is possible.

The analysis only considers the cost of treatment (therapeutic and pharmaceutical) and does not consider the impact on wider health and social care service use. Unit costs are based on Australian national costs, taking the perspective of a government payer.

This Australian economic model is not applicable to the UK context until the model structure and inputs are validated to ensure they are appropriate for the UK. Furthermore, additional analysis is needed to convert Australian unit costs into UK-equivalent unit costs. In the study's current form, the findings cannot be used to inform decisions about UK practice or policy.

De novo economic modelling, trauma-focused cognitive behavioural therapy for children who have been sexually abused

Introduction

The Guideline Committee was interested in conducting new analysis on trauma-focused cognitive behavioural therapy (T-CBT) for children who have been sexually abused.

The analysis is based on the results of a good quality meta-analysis, drawing on evidence from 10 non-UK RCTs (9 US and 1 Canadian) with a large combined sample size (n=847) (MacDonald et al. 2012 ++). Included studies were conducted before 2001.

The intervention is T-CBT and this is compared to 'treatment as usual'. In 9 studies, treatment as usual was supportive unstructured psychotherapy and 1 study used a waitlist control group. There were 6 types of T-CBT interventions in the meta-analysis and they varied with respect to the number and duration of sessions, whether they were provided to the child alone (in either group or individual sessions) and whether they were provided to both parent and child (either through separate or joint sessions, in individual or group settings).

The meta-analysis reports the results for the periods of post-treatment, 3-6 months follow-up, and 1+ years follow-up. The meta-analysis synthesised the results for the

primary outcomes of the child's psychological functioning (post-traumatic stress disorder, depression and anxiety) and the child's behaviour problems (externalising behaviour and sexual behaviour).

Participants in the RCTs were recruited from a range of sources. Participants could have been referred to the study by their parents, child protective services, the criminal justice system or health and mental health providers (Burke et al. 1996; Celano 1996; Cohen 1998; Cohen 2004; Deblinger 1996, 1999; Deblinger 2001; King 2000, cited in MacDonald et al. 2012 ++).

The indicated population are children and adolescents aged between 2 and 18 years who have experienced sexual abuse (as defined by trialists) and may or may not be symptomatic (for either psychological or behavioural problems) (MacDonald et al 2012 ++, pp17, 24). Five of the 10 studies included a mix of both symptomatic and asymptomatic children and the remaining studies included only symptomatic children. This is important because the authors assume this could limit the ability of the intervention to show effectiveness (MacDonald et al. 2012 ++, p24). It is also important to note that participants' age varied widely. This may impact the size of the intervention's effectiveness if we believe that age may have a differential impact on different outcomes. We may think this is the case if we consider that there are different patterns of impact for different age groups, especially when considering a developmental perspective. For example, preschool children are likely to experience anxiety, nightmares, externalising behaviour and inappropriate sexual behaviours; school-aged children are likely to experience problems at school, hyperactivity and nightmares and, finally, adolescents are more likely to experience depression, generalised anxiety, suicidal, self-injurious behaviour, or substance misuse (MacDonald 2012 ++, p11).

A majority of the studies in the meta-analysis provided supportive unstructured psychotherapy as 'treatment as usual'. We wanted to find out whether this was true in the English context. Based on our brief review of the literature, it is not clear, on a national level, what services are being provided to sexually abused children (Allnock 2009, p23). The implication is that, if less effective treatments are being offered in England, then the treatment effects observed in the meta-analysis are likely to be greater.

Methods

The aim of the analysis is to undertake a cost–consequence analysis of T-CBT compared to treatment as usual.

The cost perspective includes only intervention costs. The time horizon is the same as in the meta-analysis. For intervention costs, this is between 6 to 20 weeks. For outcomes, the time horizon reflects post-treatment, short term (3-6 months) and long term (1+ years). The cost–consequence analysis presents results for the primary outcomes of post-traumatic stress disorder, depression, anxiety, sexualised behaviour and externalising behaviour.

Intervention effectiveness

T-CBT is more effective than supportive unstructured psychotherapy for the outcomes of post-traumatic stress disorder and anxiety and has weak evidence of effectiveness for depression. For the outcomes of child behaviour problems and sexual behaviour, T-CBT was not more effective than supportive unstructured psychotherapy.

For the outcome of post-traumatic stress disorder, there was a statistically significant small to medium effect size in the post-treatment, 3-6 months, and 1-year measurements: post-treatment effect, -0.44 (95% CI -0.73, -0.1), 3-6 months, -0.39 (95% CI-0.74, -0.04), 1+ year follow-up, -0.38 (95% CI -0.65, -0.11).

For the outcome of anxiety, there was a statistically significant small effect size in the post-treatment, 3-6 months, and 1-year measurements: post-treatment effect, -0.23 (95% CI -0.42, -0.03), 3-6 months follow-up, -0.38 (95% CI -0.61, -0.14), 1+ year follow-up, -0.28 (95% CI -0.52, -0.04).

For the outcome of depression, we undertook further analysis through simulations which found that between 0% and 10.8% of individuals improved in the post-treatment period, 0% and 12.1% improved in the 3-6-month follow-up period and between 0% and 10.7% improved in the 1+ year follow-up period. These results are dependent on both the initial baseline depression scores and the size of the intervention's effect on reducing depressive symptoms. It is important to note that the size of the intervention's effect was large, but that this was only statistically significant in the 3-6-month follow-up period. In the short term, the mean reduction in

depression scores was -1.84, (95% CI -3.41, -0.27). This is in contrast to the post-treatment and 1+ year follow-up effect, which were not statistically significant from the comparison group. Effects for post-treatment and 1+ year follow-up periods are, respectively, -1.92 (95% CI, -4.24, 0.40) and -1.19 (95% CI, -2.70, 0.32).

For the outcome of externalising behaviour, the meta-analysis showed that there were no statistically significant differences between groups. The mean and 95% confidence intervals for externalising behaviour problems are, for post-treatment, -0.12 (95% CI, -0.40, 0.17), 3-6 months follow-up, -0.11 (95% CI, -0.42, 0.21), and 1+ year follow-up, 0.05 (95% CI, -0.16, 0.27).

Intervention costs

The costs of the intervention vary because the meta-analysis combined several different types of T-CBT interventions, including:

- child only group
- child only group + parent support group (not CBT)
- child only group + parent only group
- individual sessions for the child
- individual sessions for the child and parent (joint sessions)
- individual sessions for the child and parent (separate sessions).

We provide estimates of intervention costs for each type of T-CBT included in the meta-analysis. The studies did not always provide all the information needed to estimate costs. In these instances we made assumptions based on information in other studies.

There are 3 main intervention costs. The first is the therapist time for directly providing the intervention (and the associated time to complete administrative, patient-related tasks). The second is the time to train the therapist. The third is supervision, time required of the supervisor and the therapist.

We provide 2 sets of intervention costs. One set of costs includes only the therapist's time in providing the intervention and the time for training; effectively, it excludes the costs of supervision. The second set of costs includes all 3 cost components (that is, it includes supervision costs). The reason we present 2 sets of costs is that clinical

research studies may have provided supervision to ensure that the therapists are delivering the intervention 'as intended' (meaning fidelity to the model). However, in real-world situations, supervision may not occur as frequently or may not be provided at all.

We also present lower, middle, and upper intervention cost estimates depending on the professional providing the intervention. The types of providing professionals varied. We estimated UK-equivalents to be a mental health nurse, a children's social worker and a clinical psychologist or consultant psychiatrist. The hourly unit cost for each professional's time is, respectively, £40/hour, £57/hour, and £139/hour (Curtis and Burns 2015).

Cost estimates are presented per 'treatment unit'. This means that if the sessions are provided for the child only, then the costs relate to the child. Where the sessions are provided to both parent and child (jointly or separately), 'treatment unit' reflects the cost of providing therapy to the parent–child dyad.

Across intervention types, the inclusion of supervision triples the intervention cost. As expected, group-based T-CBT costs less than individual T-CBT. Likewise, interventions provided by a clinical psychologist or consultant psychiatrist are more costly than when provided by a mental health nurse or children's social worker.

Intervention costs per treatment unit vary (rounded to nearest hundred):

- child group sessions range from £100 to £570 when excluding supervision costs and increase to a range between £300 and £1,800 when including supervision costs
- child group sessions + parent support group (not CBT) range from £200 to £700 (excluding supervision) and £600 to £2,200 (including supervision)
- child group sessions + parent group sessions (both are T-CBT) range from £300 to £2,500 (excluding supervision) and £900 to £6,800 (including supervision)
- individual child sessions range from £500 to £3,000 (excluding supervision) and £1,800 to £11,500 (including supervision)
- joint individual sessions for child and parent range from £900 to £3,200 (excluding supervision) and increase to £3,000 to £10,400 (including supervision)

- separate individual sessions for the child and parent (separate sessions) range from £900 to £5,900 (excluding supervision) and increase to £3,000 and £18,700 (including supervision).

Cost–consequence results

In summary, T-CBT is more effective than supportive unstructured psychotherapy for the outcomes of post-traumatic stress disorder and anxiety and has weak evidence of effectiveness for depression. For the outcomes of child behaviour problems and sexual behaviour, T-CBT was not more effective than supportive unstructured psychotherapy. The additional costs of T-CBT to achieve those outcomes vary across the 6 types of T-CBT interventions described previously.

There is not enough evidence to assess the cost-effectiveness of T-CBT compared to supportive unstructured psychotherapy.

This analysis provided information about the additional costs of the intervention and how the intervention changes outcomes for children. In this sense, our cost–consequence analysis is missing additional information, such as the potential impact of the intervention on an individual's use of public sector services, which would give this economic analysis a wider perspective. There was no information about wider impacts on service use. In conclusion, decision-makers will need to decide whether the additional improvements for children are worth the additional costs.

If decision-makers decide that T-CBT is cost-effective, it is important to note that we cannot conclude that the 'less costly' group-based T-CBT is more cost-effective than the 'more costly', individual T-CBT. Likewise, we cannot conclude that the 'less costly' provision of T-CBT by mental health nurse or child social worker is more cost-effective compared to the 'more costly' clinical psychologist and consultant psychiatrist. The reason is that these studies were not designed to answer those questions. Rather, they were designed to conclude whether T-CBT is more effective than supportive unstructured psychotherapy. Moreover, the meta-analysis combined the available studies even though T-CBT was provided in different ways and delivered by different professionals.

Evidence statements

ES29	**ES29. Impact of child-focused adaptation of the Incredible Years programme on outcomes for foster children who have experienced substantiated neglect** There is evidence from 1 moderate quality US RCT (Linares et al. 2012+) that provision of a child-focused adaption of the Incredible Years Programme to foster children between the ages of 5 and 8 who have experienced substantiated neglect is no better than usual care in improving children's health and wellbeing. Those in the intervention group showed less improvement than usual care in relation to foster parents' reports of physical aggression and child self-control (effect sizes not reported).
ES30	**ES30. Impact of resilient peer treatment on outcomes for socially withdrawn, maltreated preschool children** There is evidence from 1 poor quality US RCT (Fantuzzo et al. 2005 -) that provision of a resilient peer treatment intervention to socially withdrawn, maltreated preschool children has a significant impact, compared to a control intervention, on children's play behaviours, including collaborative classroom play, with medium effect size (partial eta-squared =.19), solitary classroom play, with medium effect size (partial eta-squared =0.14) and the play interaction (partial eta-squared =.16), play disruption (partial eta-squared =.07), and play disconnection (partial eta-squared =.14) subscales of the Penn Interactive Peer Play Scale. The intervention also has significant impact on internalising behaviour, with medium effect size (partial eta-squared =0.14) and externalising behaviour, with small to medium effect size (partial eta-squared =0.10). Effect sizes reported are for both maltreated and non-maltreated children. However, multiple analysis of variance suggested that the intervention was equally effective for both groups. No effect of treatment was found for levels of associative play or social attention in dyadic play-corner interactions or classroom free-play, or on levels of verbal assertion using the Social skills scale of the Social Skills Rating System (no effect sizes reported).
ES31	**ES31. Attachment and biobehavioural catch-up delivered to parents of maltreated children – impact on quality of parenting and parent-child relationships** There was a small amount of moderate quality evidence from 1 moderate-quality systematic review (Goldman Fraser et al. 2013 +) citing 1 US RCT, rated as medium risk of bias by the authors, that providing attachment and biobehavioural catch-up (ABC) to parents of maltreated children results in improved parenting quality. The study showed improved attachment behaviour, including decreased proportions of disorganised attachment, and increased proportion of organised attachment (Bernard et al. 2012, cited in Goldman Fraser et al. 2013 +, effect sizes not reported).
ES32	**ES32. Attachment and biobehavioural catch-up or a related intervention delivered to parents of maltreated children – impact on children's health and wellbeing** There was some evidence of mixed quality from 1 moderate quality systematic review citing 1 US RCT rated as medium risk of bias (Bernard et al. 2012, cited Goldman Fraser et al. 2013 +) and 1 poor quality US RCT (Lind et al. 2014 -) that provision of attachment and biobehavioural catch-up to parents of maltreated children has a positive impact on negative emotional expression by children (d=0.42, Lind et al. 2014 -; no effect size reported) (Dozier et al. 2008, cited in Goldman Fraser et al. 2013 +).

	However, the scoring manual for this measure is unpublished, meaning that the validity of this measure is unclear.
ES33	**ES33. Attachment and biobehavioural catch-up delivered to foster carers of maltreated children** There is evidence from 1 moderate quality systematic review citing 1 US RCT, rated as medium risk of bias by the authors (Sprang et al. 2009, cited in Goldman Fraser et al. 2013 +) that provision of an attachment and biobehavioural catch-up intervention to foster carers of maltreated children has a positive impact on risk of abuse and neglect by those carers, with large effect size (partial eta-squared =0.791). However, it should be noted that risk of abuse was measured in foster parents, rather than the parents who had initially maltreated the child.
ES34	**ES34. Attachment and biobehavioural catch-up delivered to foster carers of maltreated children – impact on quality of parenting and parent–child relationships** There is evidence, from 1 moderate quality systematic review citing a US RCT rated as medium risk of bias by the authors (Dozier et al. 2009, cited in Goldman Fraser et al. 2013 +) that provision of an attachment and biobehavioural catch-up intervention to foster carers of maltreated children has a positive impact on avoidant attachment behaviour (no effect sizes reported), although no impact on secure attachment behaviour.
ES35	**ES35. Attachment and biobehavioural catch-up delivered to foster carers of maltreated children – impact on children's health and wellbeing** This evidence statement is based on a moderate quality systematic review (Goldman Fraser et al. 2013 +) which reports 2 US RCTs rated as medium risk of bias (RCT1 reported in Dozier et al. 2006, 2008, 2009; Lewis-Moriarty et al. 2012; RCT 2 reported in Sprang et al. 2009). There was an overall trend towards impact of attachment and biobehavioural catch-up delivered to foster carers on measures of children's health and wellbeing. RCT1 found significant impact on cortisol levels and a theory of mind task (Dozier et al. 2006; Lewis-Moriarty et al. in press, cited in Goldman Fraser et al. 2013 +), but not on parent daily report (Dozier et al. 2006, cited in Goldman Fraser et al. 2013 +). RCT2 found significant impact with large effect size on both internalising and externalising behaviour (partial eta squared =0.436; 0.511 respectively) (Sprang et al. 2009, cited in Goldman Fraser et al. 2013 +).
ES36	**ES36. Attachment and biobehavioural catch-up delivered to foster carers of maltreated children – impact on parents' health and wellbeing** There was evidence from 1 moderate quality systematic review citing a US RCT rated as medium risk of bias by the authors (Sprang et al. 2009, cited in Goldman Fraser et al. 2013 +) that attachment and biobehavioural catch-up has a positive impact on foster carer stress levels, with large effect size (partial eta-squared =0.59)
ES37	**ES37. Child–parent psychotherapy (CPP) – impact on parenting and parent–child relationships** This evidence statement is based on 2 US RCTs. RCT1 is cited in a moderate quality systematic review, and rated medium risk of bias (Cichetti et al. 2006, cited in Goldman Fraser et al. 2013 +) and reported in a subsequent paper (Stronach et al. 2006 +) rated as moderate quality. RCT2 is cited in a moderate quality systematic review, and rated medium

	risk of bias (Toth et al. 2002, cited in Goldman Fraser et al. 2013 +). The RCTs provide equivocal evidence of impact of CPP on parenting and parent/child relationships. RCT1 found that providing CPP to maltreating families resulted in a significant positive impact compared to usual care on rates of secure attachment immediately post-intervention, with large effect size (h=1.16 to 1.39) and at 12-month follow up with small effect size (ES=0.28), rates of disorganised attachment post-intervention, with large effect size (Cohen's h=0.83) (but not at 12 month follow-up) (ES=0.17) and rates of becoming securely attached immediately post-treatment, with large effect size (Cohen's h=1.34). However, RCT2 found no impact on 3 out of 4 measures of negative self-representations (Toth et al. 2002, cited in Goldman Fraser et al. 2013 +, no effect sizes given).
ES38	**ES38. Child–parent psychotherapy (CPP) – impact on children's health and wellbeing** This evidence statement is based on 2 US RCTs. RCT1 is cited in a moderate quality systematic review, and rated medium risk of bias (Cichetti et al. 2006, cited in Goldman Fraser et al. 2013 +) and reported in a subsequent paper (Stronach et al. 2006 +) rated as moderate quality. RCT2 is a moderate-quality US RCT reported in Lieberman (2005, 2006 +) and Ghosh et al. (2011 +). The RCTs provide equivocal evidence of impact of CPP on children's health and wellbeing. RCT1 found no significant impact of the intervention on behaviour problems as measured by the Child Behaviour Checklist at 12-month follow-up (no effect size reported) (Stronach et al. 2006 +). However, RCT2 found significant impact on post-traumatic stress disorder symptoms, with medium effect size (d=0.63) and on rates of post-traumatic stress disorder diagnosis, with medium effect size (phi=0.37) (Lieberman et al. 2005 +). RCT2 also found evidence that this intervention was more effective for children with higher levels of trauma (Ghosh et al. 2011 +).
ES39	**ES39. Child–parent psychotherapy (CPP) – impact on parents' health and wellbeing** There was evidence from 1 moderate quality US RCT reported in 3 papers (Ghosh et al. 2011 +; Lieberman et al. 2005, 2006) and a second US RCT (Toth et al. 2015 +) focusing on a subsample of neglecting mothers from a previous trial (Cicchetti et al. 2006), of equivocal evidence of impact of CPP on parents' health and wellbeing. Toth et al. (2015 +) found that mothers receiving the CPP intervention showed a significantly greater improvement compared to a service as usual control on child-related psychological stress (d=2.29) but not parent-related psychological stress. Performance of CPP in relation to the active control group (psychoeducational parenting intervention) was unclear. Lieberman et al. (2005, 2006) and Ghosh et al. (2011 +) found a marginally significant impact of the intervention compared to an active control on the avoidance subscale of the clinician-administered PTSD scale, with medium effect size (d=0.5), and on maternal functioning immediately post-treatment, with small to medium effect size (d=0.37) (Lieberman et al. 2005+). However, there was no overall impact of the intervention on rates of maternal post-traumatic stress disorder diagnosis, although a difference was observed for mothers of children with higher levels of trauma (Ghosh et al. 2011 +). There was also no significant difference and a very small effect size for the re-experiencing and hyperarousal subscales of the clinician-administered post-traumatic stress disorder measure (d=0.29; d=0.19).

ES40	**ES40. Parent–child interaction therapy (PCIT) – impact on recurrence of abuse and neglect** There is a small amount of evidence from a moderate quality systematic review, citing 2 US RCTs, 1 rated medium and 1 low risk of bias (Chaffin et al. 2004, 2011, cited in Goldman Fraser et al. 2013 +) that providing PCIT to parents reduces recurrence of abuse as measured by reports to the child welfare system. One study found a hazard ratio of 0.20 in favour of the intervention group (Chaffin et al. 2011, cited in Goldman Fraser et al. 2013 +), 1 did not report effect sizes or hazard ratios (Chaffin et al. 2004, cited in Goldman Fraser et al. 2013 +).
ES41	**ES41. Parent–child interaction therapy (PCIT) – impact on risk of abuse and neglect** There is a small amount of moderate quality evidence from a moderate-quality systematic review, citing 2 RCTs (1 US, 1 country not stated), risk of bias unclear (Chaffin et al. 2004; Terao 1999 cited in Barlow et al. 2006 +) showing equivocal evidence of the impact of PCIT on risk of abuse and neglect. One study found no impact of PCIT on CAPI scores compared to the comparison group (SMD=0.03 [-0.42 to 0.48]), (Chaffin et al. 2004, cited in Barlow et al. 2006 +). One study found a significant difference in CAPI scores favouring the intervention group, with large effect size (SMD=-0.99, [95% CI1.71 to -0.27]) (Terao 1999, cited in Barlow et al. 2006+).
ES42	**ES42. Parent–child interaction therapy (PCIT) – impact on quality of parenting and children's health and wellbeing** There is a small amount of moderate quality evidence from a moderate quality systematic review, citing 1 US RCT, risk of bias unclear (Chaffin et al. 2004, cited in Barlow et al. 2006 +) that provision of PCIT to caregivers of physically abused children ages 4 to 12 results in improved parenting behaviours (SMD=0.50 [95% CI 0.04 to 0.95]), reduced parental rigidity (SMD = 0.41, 95% confidence interval -0.04 to 0.86) and problems with children (SMD=0.39 95% confidence interval -0.06 to 0.85). There is evidence of no impact on measures of externalising problems (SMD=0.06, [95% CI-0.39 to 0.51]) or internalising problems (SMD=-0.02, [95% CI-0.47 to 0.43]).
ES43	**ES43. Promoting First Relationships (PFR) – impact on quality of parenting and parent–child relationships** There was equivocal evidence from 1 poor quality US RCT (Spieker et al. 2012 -) on the impact of a PFR intervention for carers of toddlers with a recent court-ordered foster care placement on quality of parenting. The study found the intervention had an impact on caregiver sensitivity immediately post-intervention, with small to medium effect size (d=0.41), reducing to a small effect size at 6 months post-intervention (d=0.29); impact on caregiver understanding of toddlers immediately post-intervention and at 6-month follow-up, both with small to medium effect size (d=0.36, 0.39). However, impact was not statistically significant, and effect sizes were very small, both immediately post-intervention and at 6-month follow-up, for caregiver support (d=0.11, 0.18) and caregiver commitment to the child (d=-0.17, 0.16).
ES44	**ES44. Promoting First Relationships (PFR) – impact on children's health and wellbeing** There was equivocal evidence from 2 poor quality US RCTs (Oxford et al. 2013 -; Spieker et al. 2012 -) regarding the impact of PFR on children's health and wellbeing. One study found a significant impact with small to

	medium effect size on child competence immediately post-intervention (d=0.42), but this reduced to a very small effect size at 6 months post-intervention (d=-0.16). However, there was also no effect on a number of outcomes (child attachment security, child engagement, child problem behaviours, child internalising problems, emotional regulation) and the intervention performed worse than control on monthly rates of change in child competence (Spieker et al. 2012 -). One study found that being in the intervention group (compared to control group) significantly predicted reduction in sleep problems, with medium to large effect size (d=0.67) (Oxford et al. 2013 -).
ES45	**ES45. Promoting First Relationships (PFR) – impact on parents' health and wellbeing** There evidence from 1 poor quality US RCT (Spieker et al. 2012 -) that provision of PFR to carers of toddlers with a recent court-ordered foster care placement (including birth parent, foster carers and kinship carers) has no impact on caregiver health or wellbeing, including stress related to perception of caring for a difficult child, or stress related to dysfunctional caregiver–child relationship (effect sizes not reported).
ES46	**ES46. Impact of behavioural child management programme provided in response to abuse** There was evidence from 1 moderate quality systematic review, reporting 1 RCT (country not reported, risk of bias unclear) (Egan 1983, cited in Barlow et al. 2006 +) that a behavioural child management programme provided to physically abusive parents had equivocal impact on measures of quality of parenting, with no impact observed for the majority of measures, including verbal attacks, verbal commands, verbal reasoning, positive verbals and positive restraints, and family environment (no effect sizes reported). Participants in the behavioural child management programme were significantly worse than the comparison parenting group on measures of positive child affect ($p<0.05$, effect size not reported).
ES47	**ES47. Impact of cognitive behavioural therapy provided in response to abuse on quality of parenting and parent–child relationships** This evidence statement is based on 2 moderate quality systematic reviews, 1 reporting 1 RCT (country not reported, risk of bias unclear) (Kolko 1996, cited in Barlow et al. 2006 +) and 1 reporting a second US RCT (risk of bias rated medium) (Runyon et al. 2010, cited in Goldman Fraser et al. 2013 +). Overall, there was a small amount of moderate quality evidence that cognitive behavioural therapy provided to maltreating families, or to parenting–child dyads, had a significant impact on parenting behaviours including child-reported parental anger (SMD=-1.21, [95% CI -1.91 to -0.51]), a non-significant but small to medium effect size impact on parent-reported parental anger (SMD=-0.45, [95% CI -1.10 to 0.19]), and a significant impact on family problems with large effect size, as reported by children (SMD=-0.96, [95% CI -1.64 to -0.28]) but not as reported by parents (SMD = 0, [95% CI -0.64 to 0.64]) (Kolko 1996, cited in Barlow et al. 2006 +) and of parental self-reports of positive parenting ($p<0.05$, d=0.59) and self-reported reductions in corporal punishment ($p<0.05$, d=0.57) (Runyon et al. 2010, cited in Goldman Fraser et al. 2013 +).
ES48	**ES48. Impact of cognitive behavioural therapy provided in response to abuse on children's health and wellbeing** There is evidence from 1 moderate quality systematic review, citing 1 US RCT (risk of bias rated medium) (Runyon et al. 2010, cited in Goldman Fraser et al. 2013 +) that the combined parent–child cognitive behavioural

	therapy leads to a reduction in parent- and child-reported trauma symptoms ($p<0.05$, $d=0.61$), but not parent-reported internalising or externalising behaviours (no effect sizes reported).
ES49	**ES49. Impact of family behaviour therapy (FBT) for mothers with concurrent neglect and substance misuse** There is evidence from 1 poor quality US RCT (Donohue et al. 2014 -) that provision of FBT to mothers referred to child protective services for concurrent neglect and substance misuse was significantly more effective than services as usual on parent but not child outcomes, although this primarily applied to mothers for whom child neglect took a form other than exposing their child to drugs. For these mothers, but not drug-exposing mothers, FBT was associated with a reduction in child abuse risk, with small to medium effect size (partial eta squared =0.081), reducing hard drug use, with small to medium effects at 6 and 10 months (partial eta squared =0.076, 0.107). There was also a significant impact of FBT for all mothers' HIV transmission, with a small-to medium effect size at 6 months (partial eta squared =0.056). There was a significant impact of FBT compared to TAU on number of hours worked, with small-to-medium effect sizes at 6 months (partial eta squared =0.054) and 10 months (partial eta squared =0.05.) There was also a marginally significant impact of FBT compared to TAU on days of incarceration at 6 months, with small-to-medium effect size (partial eta squared =0.043), but not at 10 months. However, FBT was not significantly more effective than TAU in terms of reducing marijuana use or alcohol intoxication. It also had no significant impact on numbers of days spent by children in Department of Family Services Custody (no effect sizes provided).
ES50	**ES50. Impact of cognitive behavioural therapy for physically abusive parents** There is evidence from 1 moderate quality systematic review, reporting 1 RCT (country not reported, risk of bias unclear) (Wolfe 1981, cited in Barlow et al. 2006 +) that provision of a group-based parenting programme to physically abusive parents has a statistically significant impact on child management skills (no effect size reported), but no impact on caseworker ratings of family treatment needs, and no significant impact on child behaviour.
ES51	**ES51. Impact of I-InTERACT web-based parenting programme** There is evidence from a poor-quality RCT, with only 9 participants, (Mast et al. 2014 -) that provision of a web-based parenting programme to parents of children assessed as having experienced abusive head trauma led to improved parent–child interactions as indicated by increased use of labelled praise (relative risk not reported), increased use of reflective statements during child-directed interactions (RR=9.35), and during parent-directed interactions (RR=0.31), and child compliance following commands (effect size not reported). However, there was no significant difference in parental use of commands during child-directed interactions (RR=0.66). The study also found equivocal impact on child behaviour measures, with a positive impact on some measures (total intensity scale of Eyberg Child Behaviour Inventory, partial eta squared =0.77) a non-significant effect but of large effect size on internalising behaviours (partial eta-squared =0.65), and a non-significant impact with small effect size on externalising behaviours (partial eta-squared =0.07) or total problems (partial eta-squared =.03).

ES52	**ES52. Impact of an adapted version of the Incredible Years programme provided to foster carer/biological parent pairs** There evidence from 1 moderate-quality systematic review, citing 1 RCT, with risk of bias rated medium (Linares et al. 2006, cited in Goldman Fraser 2013 +) that provision of an adapted version of the Incredible Years programme to foster carer/biological parent pairs improves self-reported discipline strategies, with medium effect size (d=0.59), setting of clear expectations, with medium effect size (d=0.54), and co-parenting, with small to medium effect size (d=0.48) (immediately post-treatment only, not sustained at 3 months). However, no significant differences were observed for child behavioural health (caregiver-reported behaviour and conduct problems and teacher reports of disruptive classroom behaviours).
ES53	**ES53. Impact of the Incredible Years programme provided to families involved with child protective services** There is evidence from 1 moderate quality systematic review citing 1 RCT with unclear risk of bias (country not reported) (Hughes 2004, cited in Barlow et al. 2006 +) that provision of the Incredible Years programme to families involved with child protective services results in no significant impact on a non-standardised measure of parenting skills, measured using a non-standardised measure designed specifically for the study, but medium-to-large but non-significant differences favouring the intervention group for parental support for child's autonomy as measured by free play (SMD=-0.89, [95% CI -1.70 to -0.08]) and parental involvement in free play (SMD=-0.76, [95% CI -1.56 to 0.04]).
ES54	**ES54. Impact of the Incredible Years programme provided to adoptive parents, with children between 3 and 8 years** There is evidence from 1 poor quality UK RCT (Rushton et al. 2010 -) that provision of the Incredible Years Programme to adoptive parents of children between 3 and 8 years who had experienced maltreatment led to non-significant improvements in parenting skills, but with small or small to medium effect size at 6-month follow up (Expression of Feelings questionnaire, d=0.29; parenting efficacy, d=0.34, frequency of daily hassles d=0.13, intensity of daily hassles, d=0.13). There is evidence of a non-significant impact with very small effect size on child Strengths and Difficulties scores (d=0.13).
ES55	**ES55. Impact of Keeping Foster and Kinship Carers Trained and Supported (KEEP) provided to foster parents** There is moderate evidence from 1 moderate quality systematic review, citing 1 US RCT (Chamberlain et al. 2008, cited in Goldman Fraser et al. 2013 +) that provision of the KEEP intervention to foster parents of children aged 5 to 12 has a significant impact in comparison to usual care, with small effect size on the intervention on proportion of positive reinforcement (d=0.29), and on child behaviour problems (d=0.26).
ES56	**ES56. Multi-systemic therapy (MST) provided to families where abuse/neglect is occurring or has occurred – impact on incidence of abuse and neglect** There is equivocal evidence from 1 moderate-quality US RCT (Swenson et al. 2010 +) regarding the impact of MST on incidence of abuse and neglect. The study found that provision of an MST intervention adapted for child abuse and neglect (MST-CAN) to young people aged 10 to 17 and the parent implicated in child protective services has no significant impact on recurrence of child abuse and neglect, as measured by new reports to

	child protective services (no odds ratios reported). However, provision of the intervention had an impact on measures of self-reported abusive behaviours including levels of neglect (youth-reported d=0.89; parent-reported d=0.28), severe assault (youth-reported d=0.54; parent-reported d=0.57), psychological aggression (youth-reported d=0.21), minor assault (youth reported d=0.14) and non-violent discipline (youth-reported d=0.20; parent-reported d=0.57). The study also found that youth who received MST-CAN were significantly less likely to experience an out-of-home placement over 16 months with small to medium effect size (chi-squared = 3.74, p<0.05, phi=0.21).
ES57	**ES57. Multi-systemic therapy (MST) provided to families where abuse/neglect is occurring or has occurred – impact on quality of parenting and parent–child relationships** There is evidence from 1 moderate quality systematic review, citing 1 RCT (country unknown) (Brunk et al. 1987, cited in Barlow et al. 2006 +) that provision of MST has a positive impact on quality of parenting and parent–child relationships including parental effectiveness-attention (no effect size reported), and child passive non-compliance (no effect size reported) (Brunk et al. 1987, cited in Barlow et al. 2006 +).
ES58	**ES58. Multi-systemic therapy (MST) provided to families where abuse/neglect is occurring or has occurred – impact on children's health and wellbeing** There is a small amount of moderate quality evidence from 1 moderate quality US RCT (Swenson et al. 2010 +) that provision of an MST intervention adapted for child abuse and neglect (MST-CAN) to young people aged 10 to 17 and the parent implicated in child protective services has equivocal impact on child health and wellbeing, with impact on PTSD (youth-reported d=0.68, parent-reported d=0.55), parent-reported total symptoms (d=0.85), dissociative symptoms (d=0.73), internalising behaviours (d=0.71) but no impact on parent-reported externalising behaviours, parent ratings of youth social skills, youth reported depression, anxiety and anger.
ES59	**ES59. Multi-systemic therapy (MST) provided to families where abuse/neglect is occurring or has occurred – impact on parents' health and wellbeing** There is a small amount of moderate quality evidence from 1 moderate quality systematic review, citing 1 RCT (country unknown) (Brunk et al. 1987, cited in Barlow et al. 2006 +) and 1 moderate quality US RCT (Swenson et al. 2010 +) that provision of MST or an MST intervention adapted for child abuse and neglect (MST-CAN) has equivocal impact on parent health and wellbeing, with reductions in stress (no effect size reported) and therapist-reported family problems (no effect size reported), but not social system problems (Brunk et al. 1987, cited in Barlow et al. 2006 +), and reductions in psychiatric distress (d=0.63) but not overall numbers of symptoms (Swenson et al. 2010 +).
ES60	**ES60. Impact of nurse home visitation provided to families where abuse/neglect is occurring or has occurred** There is evidence from 1 moderate quality systematic review, citing 1 Canadian RCT rated by the review as low risk of bias (Macmillan et al. 2005, cited in Goldman Fraser et al. 2013 +) that provision of a nurse home visitation intervention to families who have physically abused or neglected their children leads to no significantly greater impact than usual care on risk of child abuse, child rearing attitudes, quality of the child's

	environment, family functioning or child behaviour (no effect sizes reported).
ES61	**ES61. Impact of Project Support provided to families where abuse/neglect is occurring or has occurred** There is evidence from 1 moderate quality US RCT (Jouriles et al. 2010 +) that provision of the Project Support intervention to families referred for child maltreatment can lead to lower rates of re-referral to child protective services compared to services as usual, with small to medium effect size (phi=0.29), significant impact on parenting quality, with large effect size, as measured by self-reported inability to manage childbearing responsibilities (ES=1.02, 95% CI [0.29, 1.70]), self-reported harsh parenting behaviours, (ES=0.86, 95% CI [0.15, 1.53]) and observed ineffective parenting (ES=0.96, 95% CI [0.24, 1.64]). However, the evidence suggests the intervention has no impact on parents' psychological distress (no effect size provided).
ES62	**ES62. Impact of SafeCare provided to families where abuse/neglect is occurring or has occurred** There is evidence from 1 moderate quality systematic review, citing 1 particularly large US RCT rated by the review as low risk of bias (Chaffin et al. 2012, cited in Goldman Fraser et al. 2013 +) that provision of a SafeCare intervention to maltreating parents involved with child protective services significantly reduces risk of further reports to child protective services compared to services as usual (hazard ratio =0.83, [95% CI 0.70 to 0.98]), with even greater effectiveness among preschool age children (hazard ratio =0.74, [95% CI 0.58 to 0.95).
ES63	This was replaced by EcES5.
ES64	**ES64 Impact of cognitive behavioural therapy on quality of parenting and parent–child relationships following child experiences of sexual abuse** This evidence statement is based on 1 good quality systematic review (Macdonald et al. 2012 ++) which reports a meta-analysis of 9 US and 1 Australian RCTs. This evidence indicates that cognitive behavioural therapy has a positive impact on some measures of parenting and parent–child relationships, but that these effects tend to be more reliable in the short term than in the medium and long term, as shown by large 95% confidence intervals for the data at later time points. The intervention has a positive impact on parental emotional reactions with large effect sizes in the short (mean difference -6.95, 95% CI -10.11 to -3.80), intermediate (mean difference -3.46, 95% CI -6.98 to 0.06), and long term (mean difference -4.56, 95% CI -8.37 to -0.75), but were not statistically significant in the intermediate term. There is also a positive impact on parenting skills with large effect sizes in the short term (mean difference 3.86, 95% CI 0.47 to 7.26), with large effect sizes but not statistically significant in the intermediate (mean difference 2.36, 95% CI, -1.55 to 6.28) and long term (mean difference 0.89, 95% CI, -4.89 to 3.11). Similarly, there is an impact on parental belief and support of the child with small effect sizes in the short term (standardised mean difference 0.30, 95% CI 0.03 to 0.57), and with small effect sizes but not statistically significant in the intermediate (standardised mean difference -0.32, 95% CI -0.65 to 0.01), and long term (standardised mean difference -0.10, 95% CI -0.43 to 0.23). There is an impact with large effect size, but statistically non-significant, on the following outcomes: parental attributions (mean difference 0.80, 95% CI -4.03 to 2.43), parental blame of the child (mean

	difference -1.20, 95% CI -4.47 to 2.07), parental blame of the perpetrator (mean difference -0.60, 95% CI -2.62 to 1.42), and negative impact on the parent (mean difference -1.90, 95% CI -4.67 to 0.87).
ES65	**ES65 Impact of cognitive behavioural therapy on health and wellbeing outcomes for children who have been sexually abused – post-traumatic stress disorder** There is evidence from 1 good quality systematic review (Macdonald et al. 2012 ++) which reports a meta-analysis of 9 US and 1 Australian RCTs; and 1 moderate quality systematic review (Goldman Fraser et al., 2013, +) which reports on 3 US RCTs, that cognitive behavioural therapy for children who have been sexually abused has a positive impact on post-traumatic stress disorder symptoms, on a range of measures. A positive impact was found in a meta-analysis using a range of measures (Macdonald et al., 2012 ++), with small to medium effect sizes immediately after treatment (-0.44; 95% CI -0.73 to -0.16), and in the intermediate (-0.39; 95% CI -0.74 to -0.04) and long term (-0.38; 95% CI -0.65 to -0.11). Regarding specific scales (which were not used in the meta-analysis conducted by Macdonald et al. 2012 ++), small to medium effect sizes were also observed for hypervigilance measures (d=0.40, significance values not reported, Cohen et al. 2004, cited in Goldman Fraser et al., 2013 +) and avoidance (d=0.70, significance values not reported, Cohen et al. 2004, cited in Goldman Fraser et al. 2013 +).
ES66	**ES66. Impact of cognitive behavioural therapy on health and wellbeing outcomes for children who have been sexually abused – anxiety and depression** There is evidence from 1 good quality systematic review (Macdonald et al., 2012 ++) which reports a meta-analysis of 9 US and 1 Australian RCTs; and 1 poor quality US RCT (Barbe 2004, -) that cognitive behavioural therapy has a positive impact on anxiety but an equivocal impact on depression. On measures of anxiety, Macdonald et al. (2012 ++) detected small effect sizes in the short term (-0.23; 95% CI -0.42, -0.03), small to medium effect sizes in the intermediate term (-0.38; 95% CI -0.61 to -0.14) and small effect sizes in the long term (-0.28; 95% CI -0.52 to -0.04). Macdonald et al. (2012 ++) also found a positive impact on depression with large effect sizes being detected in the short term (-1.92; 95% CI -4.24 to 0.40), the intermediate term (-1.84; 95% CI -3.41 to -0.27), and the long term (-1.19; 95% CI -2.70, 0.32); however these effects were non-significant in the short and long term. Two poor quality US RCTs (Barbe et al. 2004 -, Shirk et al. 2014 -) also found that participants with a history of sexual abuse randomised to a cognitive behavioural therapy group did not show improvements in depression compared to the control group.
ES67	**ES67. Impact of cognitive behavioural therapy on health and wellbeing outcomes for children who have been sexually abused – behaviour** There is evidence from 1 good quality systematic review (Macdonald et al. 2012 ++) which reports a meta-analysis of 9 US and 1 Australian RCTs; and 1 moderate quality systematic review (Goldman Fraser et al. 2013, +) citing 3 US RCTs, that cognitive behavioural therapy has an equivocal impact on child behaviour, with some indication of greater impact on internalising than externalising behaviours. Two studies (Cohen et al. 1996, 2004, both reported in Goldman Fraser et al., 2013 +) found a significant positive impact on total scores of child behaviour (Cohen et al. 1996,

	p<0.01, effect size not reported; Cohen et al. 2004, d=33, p<0.01), but a third did not (Deblinger et al. 2001, cited in Goldman Fraser et al. 2013 +, p-value not reported, non-significant). On measures of externalising behaviour specifically, a meta-analysis by Macdonald et al. (2012 ++) found that cognitive behavioural therapy had a positive impact on externalising behaviour, with very small effect sizes observed in the short (-0.12; 95% CI -0.40 to 0.17), intermediate (-0.11; 95% CI -0.42 to 0.21) and long term (0.05; 95% CI -0.16 to 0.27), however these were not statistically significant. In relation to internalising behaviour, Cohen et al. (1996) found a positive impact of cognitive behavioural therapy (p>0.002, effect size not presented); but Cohen et al. (2004) did not (p=non-significant). On measures of social competence both Cohen et al. (1996) and Cohen et al. (2004) (both reported in Goldman Fraser et al. 2013 +) found non-significant impact (p-values not reported).
ES68	**ES68. Impact of cognitive behavioural therapy on health and wellbeing outcomes for children who have been sexually abused – sexualised behaviour** There is evidence from 1 good quality systematic review (Macdonald et al. 2012, ++) which reports a meta-analysis of 9 US and 1 Australian RCTs that cognitive behavioural therapy has a statistically non-significant impact on child sexualised behaviour, but with medium effect size in the short term (-0.65; 95% CI -3.53 to 2.24), a small to medium effect size in the intermediate term (-0.46; 95% CI -5.68 to 4.76), and a large effect size in the long term (-1.61; 95% CI -5.72 to 2.49).
ES69	**ES69. Impact of cognitive behavioural therapy on health and wellbeing outcomes for carers/parents of sexually abused children** This evidence statement is based on 1 moderate-quality systematic review (Goldman Fraser et al. 2013, +) which reports on 2 US RCTs (Cohen et al. 2004, rated as at low risk of bias; Deblinger et al. 2001, rated as at medium risk of bias). Overall, the evidence in relation to the impact of cognitive behavioural therapy on caregiver or parental health and wellbeing outcomes is mixed. One study (Cohen et al. 2004) (measured using the Beck Depression Inventory, follow-up point unclear) found better levels of self-reported depression in parents whose children were randomised to CBT than parents whose children were randomised to the control group (d=0.38, p<0.05). A second study (Deblinger et al. 2001) found that mothers of children who were randomised to the intervention group had significantly better levels of maternal distress – intrusive thoughts (measured using the Impact of Events scale) than mothers of children randomised to the control group (p<0.05, d=not reported) but not in levels of maternal post-traumatic stress disorder symptoms measured using the Symptom Checklist-90 – Revised (p=not reported, non-significant); or maternal distress – avoidant thoughts (measured suing the Impact of events scale, p=not reported, non-significant).
ES71	Withdrawn – results no longer valid following update search.
ES72	**ES72. Impact of medium intensity psychoeducational and psychotherapeutic group treatment on health and wellbing outcomes for symptomatic, sexually abused girls between the ages of 6 and 14** There is evidence from 1 English RCT reported in a moderate quality systematic review (Trowell et al. 2002, cited in Goldman Fraser et al. 2013 +) that provision of a medium intensity psychoeducational and psychotherapeutic group treatment is less effective than high-intensity, conventional and individual psychoanalytic therapy in improving health and

	wellbeing in sexually abused girls between the ages of 6 and 14. However, it should be noted that significance levels are not reported. Participants randomised to a to conventional individual psychoanalytic therapy of a high intensity programme showed greater improvement in levels of re-experiencing post-traumatic stress disorder than those randomised to medium intensity psychoeducational and psychotherapeutic group treatment at 12- and 24-month follow-up (0.60; 0.79; significance values not provided but reported as significant by review authors) and persistent avoidance of post-traumatic stress disorder (0.66; 0.36; significance values not provided but reported as significant by review authors). At 12- and 24-month follow-up there were no differences between groups in persistent symptoms of increased arousal and measures of impairment (effect sizes and significance values not provided, reported as non-significant by review authors).
ES73	**ES73. Impact of prolonged exposure therapy on health and wellbeing outcomes for female adolescents with a primary diagnosis of chronic or subthreshold post-traumatic stress disorder resulting from experience of sexual abuse** There is evidence from 1 good quality US RCT (Foa et al. 2013 ++) that provision of an adapted version of prolonged exposure therapy to female adolescents between the ages of 13 and 18 years is more effective than supportive counselling in improving health and wellbeing. Between baseline and 12-month follow-up, participants in the intervention group showed significantly greater improvements, with a large effect size, in interviewer-rated post-traumatic stress disorder symptom severity (d=0.81, p<.02), self-reported post-traumatic symptom disorder severity (p=.02, effect size not reported), rates of diagnosis of post-traumatic stress disorder (p=.01, effect size not reported), self-reported depression severity (p=.02, effect size not reported) and interviewer-rated functioning (p=.01, effect size not reported). At 12-month follow-up, significantly more participants in the intervention group were classed as 'good responders' to treatment (p=.02; score of ≤8 on the Child PTSD Symptom Scale – Interview) than those in the comparison group. Despite the overall trend of a positive effect for prolonged exposure therapy the proportion of participants who were classed as good responders at post-treatment who then maintained this score at 12-month follow-up did not differ significantly by group (p=.53).
ES74	Replaced by EcES6.
ES91	**ES91. Attachment-based intervention – impact on quality of parenting and parent–child relationships** There was a small amount of moderate-quality evidence from 1 moderate quality systematic review (Goldman Fraser et al. 2013 +) citing 1 US RCT rated as medium risk of bias by the authors (Moss et al. 2011, cited in Goldman Fraser et al. 2013 +), that providing an attachment-based home visiting intervention to parents of maltreated children results in improved parenting quality. The study showed improved maternal sensitivity, with small to medium effect size (d=0.47), higher rates of progression from disorganised to organised attachments, with medium effect size (r=0.37) and from insecure to secure attachment, with medium effect size (r=0.36) (Moss et al. 2011, cited in Goldman Fraser et al. 2013 +).
ES92	**ES92. Attachment-based intervention – impact on children's health and wellbeing**

	There was evidence from 1 moderate quality systematic review citing 1 US RCT rated as medium risk of bias (Moss et al. 2011, cited Goldman Fraser et al. 2013 +) that providing an attachment-based home visiting intervention to parents of maltreated children has no impact on internalising or externalising behaviour in children (effect sizes not reported).
ES185	**ES185. Impact of Family Assessment Response on incidence of abuse and neglect** There is evidence from 1 moderate quality US RCT (Winokur et al. 2014 +) that safety outcomes for families where low to moderate levels of abuse or neglect were thought to be present were the same whether they received a Family Assessment Response or Investigation Response as part of a differential response model.
ES186	**ES186. Impact of Early Intervention Foster Care on placement stability** There is evidence from 1 moderate quality US RCT (Fisher et al. 2005 +) that provision of the Early Intervention Foster Care intervention is associated with fewer breakdowns of permanent placements among children aged between 3 and 6 with a history of maltreatment (p=0.02, no effect size reported).
ES187	**ES187. Impact of cognitive behavioural therapy on satisfaction with services** There is evidence from 1 poor quality US RCT (Shirk et al. 2014 -) that user satisfaction is not higher following an individual cognitive behavioural therapy treatment modified to address the consequences of interpersonal trauma than following usual care.
ES189	**ES189. Impact of a psychodynamic intervention 'Letting the Future In' on parent and caregiver wellbeing** There is evidence from 1 moderate quality UK RCT (Carpenter et al. 2016 +) that provision of a psychodynamic intervention ('Letting the Future In') is no more effective than a waitlist control in reducing the proportion of parents with clinical level parenting stress scores.
ES190	**ES190. Impact of wraparound facilitation provided to families where abuse/neglect is occurring or has occurred** There is evidence from 1 moderate quality Canadian RCT (Browne et al. 2014+) that provision of a wraparound facilitation intervention is no more effective than usual child protective services in improving levels of children's impairment (p=non-significant, d=0.14, 95% CI -0.12 to 0.52), ratings of behavioural and emotional strengths (p=non-significant, d=-0.24, 95% CI-0.37 to 0.29) or attainment of developmental milestones (p=non-significant, d=-0.02, 95% CI -0.53 to 0.49). The intervention is also no more effective than usual child protective services in improving levels of maternal depression (p=non-significant, d=0.25, 95% CI -0.07 to 0.57) or parental stress (p=non-significant, d=0.10, 95% CI -0.19 to 0.40).
ES191	**ES191. Impact of revictimisation prevention intervention on adolescent girls aged 12 to 19 who had experienced abuse or neglect** There is evidence from 1 moderate quality US RCT (DePrince et al. 2015 +) that there is no significant difference in effectiveness between a revictimisation intervention based on social learning theory and feminist approaches, compared to 1 based on executive functioning and risk detection theory. It was unclear whether either approach led to improvements in revictimisation rates (data not reported in study).

ES192	**ES192. Impact of an intensive family preservation intervention on families involved with child protective services for concerns related to parental substance misuse** There is evidence from 1 poor quality UK study (Forrester et al. 2013 -) that an intensive family preservation intervention for families involved with child protective services for concerns related to parental substance misuse is more effective than no service in improving family cohesion, with large effect size (d=-1.27, 95% CI -2.30 to -0.24) and family functioning (OR=1.5, 95% CI 0.29 to 7.75), but not effective in improving family expressiveness, levels of conflict or children's behaviour. There is also evidence that the intervention is more effective than no service in terms of rates of children entering care at some point (p=0.001) or permanently (p<0.01), and in reducing parental use of drugs/alcohol, (OR=12.14, 95% CI 1.19–123.62, p<0.05) and psychological stress (OR=0.15 CI 0.03–0.85, p<0.05).
ES193	**ES193. Impact of intervention for children aged 4 to 6 who have been exposed to intimate partner violence and their mothers** Evidence from 1 poor quality US RCT (Graham-Bermann et al. 2015 -) that provision of a 'kids club' intervention to children aged 4 to 6 who have been exposed to intimate partner violence, and an empowerment group for their mothers, is unclear regarding the impact on children's internalising behaviours.
ES194	**ES194. Impact of a trauma-informed parenting intervention for adoptive parents of children aged 5 to 12** There is evidence from 1 moderate-quality US RCT (Purvis et al. 2015 +) that provision of a trauma-informed group parenting intervention to adoptive parents of children aged 5 to 12 who have experienced abuse or neglect has a significant impact on child behaviour, with small to medium effect size (partial eta squared=0.09) and some elements of trauma symptoms, including anxiety (with small effect size, partial eta squared=0.04), depression with small effect size (partial eta squared=0.04), anger and aggression with small effect size (partial eta squared=0.06), post-traumatic stress (PTS) arousal, with small to medium effect size (partial eta squared=0.09) but not PTS intrusion, PTS avoidance, dissociation or sexual concerns.
EcES4	**EcES4. Cost-effectiveness of family assessment response** There is insufficient cost-effectiveness information about different assessment approaches when responding to families who have been referred to child protective services. One moderate quality US RCT (Winokur et al. 2015 +) compared 2 different child welfare assessment approaches in response to low-to-moderate risk families referred to child protective services. Overall, the relevance of this cost-effectiveness analysis to the UK context is not clear and further research is necessary.
EcES5	**EcES5. Cost-effectiveness of parenting intervention (Incredible Years) for caregivers of non-relative adoptive children** There is insufficient cost-effectiveness information regarding social and psychological interventions aimed at adoptive parents of children between ages 3-8 years placed for non-relative adoption during the first 18 months of placement with serious behavioural difficulties. Only 1 UK economic evaluation was identified (Rushton et al. 2010 -). The quality of the economic evaluation was good, but the validity of the findings is unclear due to poor study design.
EcES6	**EcES6. Cost-effectiveness of interventions following sexual abuse**

	There is limited economic evidence on interventions for sexually abused children. Two UK studies were identified: 1 focused on sexually abused girls (McCrone et al 2005 -) and the other on sexually abused children (Carpenter et al. 2016 +). One UK economic evaluation (Carpenter et al. 2016 +) is a moderate sized pragmatic RCT (n=242) comparing individual psychodynamic therapy vs waitlist control group provided to sexually abused children, most of whom were girls (75%). For the whole sample of young and older children, the intervention has mixed cost-effectiveness in the short-term (6 months follow-up). The intervention was trending toward improvement but was not statistically significant in relation to the percentage of children with clinical levels of symptoms, but was statistically more effective than the comparison group for the outcome of percentage of children with 'one or more significant difficulties'. For the subgroup of young children only, the intervention was not cost-effective in the short-term (6 months follow-up) for the combined outcome of percentage of children with 'clinical levels of symptoms' and 'one or more significant difficulties'. The intervention costs an additional £2,298 per child (price year unclear). The economic evaluation is limited and only includes intervention costs. It does not report on changes in health and social care services. Authors report that a full economic evaluation will be provided in a separate report (not available to us currently). One UK economic evaluation (McCrone et al. 2005 -) based on a small sample RCT (n=71) compared individual vs group psychotherapy provided to sexually abused girls. In both groups, caregivers were provided with support. Individual psychotherapy is more cost-effective than group psychotherapy for the PTSD subscales of re-experiencing and persistent avoidance at 12 and 24 months follow-up. For the PTSD subscale of increased arousal, there were no differences between groups meaning that group psychotherapy is cost-effective. For the outcome of impairment, as measured by the Kiddie Global Assessment Scale, there were no differences between groups, meaning that group psychotherapy is cost-effective. The incremental cost of individual psychotherapy relative to group psychotherapy is £1,246 per child. The evaluation only includes intervention costs and does not measure if there were any changes in health and social care service use. Using only the perspective of intervention costs only, there are mixed results regarding the cost-effectiveness of individual vs group psychotherapy.
EcES7	**EcES7. Cost-effectiveness of interventions to treat PTSD among sexually abused children** There is limited economic evidence on interventions to treat PTSD among sexually abused children. One non-UK economic modelling study was identified (Gospodarevskaya et al. 2012).[26] This modelling study is not applicable to the UK context as some of the model inputs, including clinical parameters and unit costs, are not based on UK data. The analysis compares trauma-focused cognitive behavioural therapy (T-CBT) vs T-CBT + pharmacotherapy (SSRI) vs non-directive supportive counselling vs no treatment. The model is takes a limited perspective and only considers direct treatment costs and does not include changes in health and social care services. In summary, we cannot use the results of an Australian-

[26] Note this study was not critically appraised as it is a decision model rather than an empirical study.

	based economic model to inform decision about cost-effectiveness for UK policy.

Expert witness testimony

The need for expert testimony

We found no eligible studies about response for children and young people who have experienced female genital mutilation (question 17), forced marriage (question 18) or child trafficking (question 19). In fact, there was a paucity of evidence relating to these forms of abuse across all question areas. We therefore invited testimony from experts in child sexual exploitation, female genital mutilation, forced marriage and child trafficking.

Testimony

The full testimony from the expert witnesses can be found in Appendix D. A brief summary of their testimony is given below.

For child sexual exploitation, the expert witness highlighted poor recognition of the issue by professionals and a lack of early help and prevention due to high thresholds for support. The expert witness highlighted that assessment tools were available but had not been evaluated. Effective response was conceptualised as requiring good multi-agency working and information-sharing.

For female genital mutilation, the expert witness presented a number of risk factors and indicators and referred to the current statutory risk assessment tool (this has not been evaluated). The expert witness highlighted that there can be a lack of professional confidence in asking questions of girls and young women who they think may be at risk. The expert witness stated that psychotherapeutic interventions can be beneficial in ameliorated psychological harm following female genital mutilation, but noted this is often not widely available.

The expert witness on forced marriage also highlighted a lack of professional understanding of this issue, and a tendency in practice not to use a child protection framework to deal with this issue. It was noted that working and sharing information with the whole family may not be appropriate in cases of forced marriage, meaning

that clear discussions regarding confidentiality is vital to avoid placing the young person at risk of harm. The expert witness noted that forced marriage is a criminal offence, but that few professionals are aware of this.

The expert witness on child trafficking noted that trafficking can take a range of forms, with some young people experiencing different forms over time. A tool to assist recognition was cited, but the expert witness noted that this has not been evaluated. Information was provided regarding a trial of independent child trafficking advocates, which aimed to improve 'visibility' of trafficked children and continuity of services and help them to navigate the various systems with which they may be involved. The expert witness noted that the outcomes of the trial were somewhat inconclusive, and an extension of the trial has been agreed by government.

Included studies for these review questions

For references used in economic modelling see Appendix C.

Barbe RP, Bridge AJ, Birmaher B et al. (2004) Lifetime history of sexual abuse, clinical presentation, and outcome in a clinical trial for adolescent depression. Journal of Clinical Psychiatry 65: 77-83

Barlow J, Johnston I, Kendrick D et al. (2006) Individual and group-based parenting programmes for the treatment of physical child abuse and neglect. Cochrane Database of Systematic Reviews issue 3: CD005463

Browne DT, Puente-Duran S, Shlonsky A et al. (2016) A randomized trial of wraparound facilitation versus usual child protection services. Research on Social Work Practice 26: 168-79

Carpenter J, Jessiman T, Patsios D et al. (2016) Letting the future in: a therapeutic intervention for children affected by sexual abuse and their carers. University of Bristol, Durham University, NSPCC

Danielson CK, McCart MR, Walsh K, et al. (2012) Reducing substance use risk and mental health problems among sexually assaulted adolescents: a pilot randomized controlled trial. Journal of Family Psychology 26: 628-35

Dawe S and Harnett P (2007) Reducing potential for child abuse among methadone-maintained parents: Results from a randomized con-trolled trial. Journal of Substance Abuse Treatment 32: 381-90

DePrince AP, Chu AT, Labus J, et al. (2015). Testing two approaches to revictimization prevention among adolescent girls in the child welfare system. Journal of Adolescent Health 56: S33-9

Donohue B, Azrin NH, Bradshaw K et al. (2014) A controlled evaluation of family behavior therapy in concurrent child neglect and drug abuse. Journal of Consulting and Clinical Psychology 82: 706-20

Fantuzzo J, Manz P, Atkins M et al. (2005) Peer-mediated treatment of socially withdrawn maltreated preschool children: cultivating natural community resources. Journal of Clinical Child and Adolescent Psychology 34: 320-5

Fisher PA, Nurraston B, Pears KC (2005) The Early Intervention Foster Care Program: permanent placement outcomes from a randomized trial. Child Maltreatment 10: 61-71

Foa EB, McLean CP and Capaldi S et al. (2013) Prolonged exposure vs supportive counseling for sexual abuse-related PTSD in adolescent girls: a randomized clinical trial. Journal of the American Medical Association 310: 2650-7

Forrester D, Holland S, Williams A, et al. (2016) Helping families where parents misuse drugs or alcohol? A mixed methods comparative evaluation of an intensive family preservation service. Child & Family Social Work, 21: 65-75

Ghosh Ippen C, Harris WW, Van Horn P et al. (2011) Traumatic and stressful events in early childhood: can treatment help those at highest risk? Child Abuse and Neglect 35: 504-13

Goldman Fraser J, Lloyd SW, Murphy RA et al. (2013) Child exposure to trauma: comparative effectiveness of interventions addressing maltreatment. Comparative Effectiveness Review 89: 1-161

Gospodarevskaya E and Segal L (2012) Cost-utility analysis of different treatments for post-traumatic stress disorder in sexually abused children. Child and Adolescent Psychiatry and Mental Health 6: 15

Graham-Bermann SA, Miller-Graff LE, Howell KH, et al. (2015) An efficacy trial of an intervention program for children exposed to intimate partner violence. Child Psychiatry and Human Development 46: 928-39

Jouriles EN, McDonald R, Rosenfield D et al. (2010) Improving parenting in families referred for child maltreatment: a randomized controlled trial examining effects of Project Support. Journal of Family Psychology 24: 328-38

Leenarts LE, Diehle J, Doreleijers TA et al. (2013) Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: a systematic review. European Child and Adolescent Psychiatry 22: 269-83

Lieberman AF, Ghosh Ippen C, Van Horn P (2006) Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. Journal of the American Academy of Child and Adolescent Psychiatry 45(8): 913-18

Lieberman AF, Van Horn PJ, Ghosh Ippen C (2005) Toward evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence. Journal of the American Academy of Child and Adolescent Psychiatry 44: 1241-8

Linares LO, Li MM, Shrout PE (2012) Child training for physical aggression? Lessons from foster care. Children and Youth Services Review 34: 2416-22

Lind T, Bernard K, Ross E et al. (2014) Intervention effects on negative affect of CPS-referred children: results of a randomized clinical trial. Child Abuse and Neglect 38: 1459-67

Macdonald G, Higgins J, Ramchandani P et al. (2012) Cognitive-behavioural interventions for children who have been sexually abused: a systematic review. Campbell Systematic Reviews 14: 111

Mast JE, Antonini TN, Raj SP et al. (2014) Web-based parenting skills to reduce behavior problems following abusive head trauma: a pilot study. Child Abuse and Neglect 38: 1487-95

McCrone P, Weeramanthri T, Knapp M et al. (2005) Cost-effectiveness of individual versus group psychotherapy for sexually abused girls. Child and Adolescent Mental Health 10: 26-31

Oxford ML, Fleming CB, Nelson EM et al. (2013) Randomized trial of promoting first relationships: effects on maltreated toddlers' separation distress and sleep regulation after reunification. Children and Youth Services Review 35: 1988-92

Parker B and Turner W (2013) Psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused: a systematic review. Campbell Collaboration 9(13)

Purvis KB, Razuri EB, Howard ARH et al. (2015) Decrease in behavioral problems and trauma symptoms among at-risk adopted children following trauma-informed parent training intervention. Journal of Child and Adolescent Trauma 8: 201-10

Rushton A, Monck E, Leese M et al. (2010) Enhancing adoptive parenting: a randomized controlled trial. Clinical Child Psychology and Psychiatry 15: 529-42

Shirk SR, DePrince AP, Crisostomo PS et al. (2014) Cognitive behavioral therapy for depressed adolescents exposed to interpersonal trauma: an initial effectiveness trial. Psychotherapy 51: 167-79

Spieker SJ, Oxford ML, Kelly JF et al. (2012) Promoting First Relationships: Randomized trial of a relationship-based intervention for toddlers in child welfare. Child Maltreatment 17: 271-86

Spieker SJ, Oxford ML, Fleming CB (2014) Permanency outcomes for toddlers in child welfare two years after a randomized trial of a parenting intervention. Children and Youth Services Review 44: 201-6

Stronach EP, Toth SL, Rogosch F et al. (2013) Preventive interventions and sustained attachment security in maltreated children. Development and Psychopathology 25: 919-30

Swenson CC, Schaeffer CM, Henggeler SW et al. (2010) Multisystemic therapy for child abuse and neglect: a randomized effectiveness trial. Journal of Family Psychology 24: 497-507

Toth SL, Sturge-Apple ML, Rogosch FA et al. (2015) Mechanisms of change: testing how preventative interventions impact psychological and physiological stress functioning in mothers in neglectful families. Development and psychopathology 27: 1661-74

Trowell J, Kolvin I, Weeramanthri T et al. (2002) Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. British Journal of Psychiatry 180(3): 234-47

Winokur M, Ellis R, Drury I et al. (2014) Answering the big questions about differential response in Colorado: safety and cost outcomes from a randomized controlled trial. Child Abuse and Neglect 39: 98-108

3.9 Responding to abuse and neglect – aspects of professional practice that support and hinder

Introduction to the review question

The purpose of this question was to ascertain what aspects of professional practice support and hinder responding to children and young people who are experiencing, or who have experienced, abuse and neglect. ‘Aspects of professional practice’ were defined as including issues such as case management; communication and engagement with children, young people and families; building trust with families and co-working across disciplines. This question sought to explore professional practices which do not fit easily within the concept of ‘an intervention’. This review question, focusing on ‘aspects of professional practice and ways of working’, was based on the assumption that not all work concerning children and young people who are

experiencing or have experienced abuse and neglect is easily conceptualised as discrete ‘interventions’ with clearly identifiable elements and outcomes. These interventions are often identified with manualised models or programmes, which form a part, but certainly not the whole of, work with vulnerable children and families. This question therefore sought to explore professional practices relevant to responding to abuse and neglect.

Of the 23 included studies, 1 was a moderate quality mixed method study and 2 were poor quality mixed method studies. The remainder were qualitative studies with either children and young people, caregivers or professionals. Of the qualitative studies, 5 were rated as good quality (++), 11 were rated as moderate quality (+) and 5 were rated as poor quality (-). Common methodological flaws in the poor quality, and some of the moderate quality studies, included: insufficient consideration and reporting of ethics procedures, including obtaining informed consent; limited information regarding methodology including sampling, data collection and analysis; little consideration of context or diversity of opinion between participants in some studies. Some of these limitations may reflect the fact that a number of these papers are ‘grey’ literature published by charities and campaigning organisations, rather than peer-reviewed studies.

Review questions

20. What aspects of professional practice and ways of working support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect?

Question 20 also included material relevant to the following questions:

1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

Summary of the review protocol

The protocol sought to identify studies that would identify what aspects of professional practice and ways of working support and hinder response to children and young people who are experiencing, or have experienced, child abuse and neglect.

Study designs that were included for this question were process evaluation, ethnographic and observational studies of practice and analyses of serious case review data.

Full protocols can be found in Appendix A.

Population

For question 20:

Children and young people (under 18) who are experiencing, or have experienced abuse or neglect, and/or their caregivers and families.

Practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and their families and caregivers. For example social workers, health professionals, those working in education, voluntary sector providers.

For question 1:

Children and young people (under 18) who are at risk of, are experiencing, or have experienced abuse or neglect and/or their caregivers and families.

Adults over the age of 18 who experienced abuse or neglect as children reporting their childhood experiences.

For question 2:

Practitioners working with children and young people at risk of, experiencing, or who have experienced abuse and neglect, and/or their caregivers and families. For example social workers, health professionals, those working in education, voluntary sector providers.

Intervention

Response following abuse or neglect.

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children's own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings
- schools and colleges
- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Acceptability to children, young people and their caregivers and families (including as reported by adult survivors of child abuse and neglect); incidence of abuse and neglect; quality of parenting and parent-child relationships, including quality of attachment, children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM)); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials registries were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and October 2014. Update searching of the bibliographic databases searches took place in April 2016.

Summary from re-run searches

An updated search was carried out in April 2016 to identify any new studies relating to the effectiveness questions (5, 7, 9-13, 15-19) published since the original searches were conducted for this guideline. This search used the same search terms and databases as the main search.

As we originally conducted a single search for all of the original 21 questions, the search identified a large number (10,833) items which we used as a 'database' within which to search for studies relevant to our questions. This included specific searches for interventions for which evidence had already been reviewed.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs. Outputs were initially screened against an exclusion tool informed by the overall parameters of the scope.

Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific criteria for those questions. For question 20 these were as follows:

- country (study is not from Europe, Israel, Australia, Canada, USA, New Zealand)
- evidence type (study is not process evaluation, ethnographic and observational studies of practice, analyses of serious case review data or a systematic review of the above)
- population (not children and young people under 18 or experiencing or have experienced abuse or neglect, or their parents or carers OR practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and their families and caregivers – for example, social workers, health professionals, those working in education, voluntary sector providers)
- topic (study does not have a specific focus on exploring aspects of professional practice or ways of working in relation to response to abuse and neglect).

For questions 1 and 2 these were as follows:

- country (study is not from the UK)
- evidence (not an empirical study including qualitative studies, qualitative components of effectiveness and mixed methods studies, survey studies or systematic reviews of these study types)
- population (population is not children and young people who are at risk of, are experiencing, or have experienced abuse or neglect; their caregivers and families; adult survivors of abuse or neglect; practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families)

- topic (study does not relate to the process of recognising abuse and/or neglect, the process of assessment, services providing early help, services providing intervention following abuse or neglect).

Screening on title and abstract identified 807 papers of potential relevance to this question. Due to the high numbers of potential studies, a decision was taken to include UK studies only, and those with a clear reference to the topic in the title or abstract (n=74). After full text screening we identified 22 papers which had specific relevance to aspects of professional practice and ways of working in relation to early help. An additional Irish study (McGee et al. 2002 +) was suggested by the Guideline Committee. Although this did not meet all inclusion criteria, it was included as it was felt to be a seminal study of the views of adult survivors of abuse.

See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence

Children and young people's experiences of professionals responding to their own abuse

Description of evidence

We found 12 UK studies which examined children and young people's experiences of professionals responding to abuse and neglect. The characteristics of the studies are shown in Table 47. Nine studies included the views of adult survivors of abuse (aged >18), talking about their experiences as children and young people.

Table 47. Study characteristics – Children and young people's experiences of professionals responding to their own abuse

Author/date	Study methods	Quality rating and reason (for studies rated as poor)	Age range of participants	Type of abuse
Beckett et al. (2013)	Individual interviews with 150 young people Eight single sex focus groups with 38 young people	++	13-28	Gang-associated sexual violence and exploitation

	(plus 11 focus groups with 76 professionals)			
Children's Commissioner (2015)	Survey of 756 survivors of child sexual abuse Focus groups with 5 victim/survivor organisations	- Little methodological information provided, particularly regarding survey distribution, response rates and representativeness of resulting sample	Over 18	Sexual abuse
Cossar et al. (2011)	Activity-based interviews and workshops	+	6-17 years	Not reported but all children were on CPP
Franklin and Doyle (2013)	Qualitative interviews with 17 trafficked young people	+	15-23 years	Trafficked children
Harper and Scott (2005)	Qualitative interviews with 12 young people (plus interviews with practitioners)	+	13-19 years	Child sexual exploitation
Izzidien (2008)	Two focus groups held with 16 young people	- Relevant findings to research question, however with little methodology it is difficult to contextualise the experiences of service users. The study had a poor research design with little information or context on where the data has been collected	10-19 years	Domestic abuse
McGee (2002)	Survey of 3120 members of general population; 24% of male respondents and 30% of female respondents reported some	+	18 and over	All forms

	form of abuse in childhood			
Rees et al. (2010)	Interviews with 24 young people who had been referred to children's social care	+	11-18 Includes 5 unaccompanied asylum-seeking children	Appears to cover all forms of abuse
Richardson-Foster et al. (2012)	Qualitative interviews with 19 young people (plus 30 police officers)	+	10-19 years	Domestic abuse
Smeaton (2013)	The study aimed to collect data from conducting interviews with young people under the age of 16 (n=41) who experience running away and child sexual exploitation (CSE) (plus telephone interviews with 27 practitioners and surveying 28 voluntary sector projects working within the field)	- Survey of services is entirely of voluntary sector services, and it is unclear whether interviewed professionals represented a wider range of services – the voluntary sector perspective of the research is not highlighted or justified in the research methodology. Little consideration in the findings of how contextual and demographic factors shape participant responses	Majority under age 18. Twelve of the young people interviewed were over age of 18	Sexual exploitation
Skinner (2009)	Qualitative interviews with 9 young people (plus 6 caregivers)	+	14-16 years	All suffered rape or sexual assault
Stanley et al. (2010)	Five focus groups with 19 young people. (Also interviews 11 survivors and 10 perpetrators).	- This study could be considered poor quality because there is no consideration of ethical considerations in relation to focus groups	10-19 years	Witnessing domestic violence
Wirtz (2009)	Interviews with 8 trafficked young	++	Aged 16 and over	Trafficked children

	people (plus 15 practitioners)			

Narrative summary

The following barriers to effective professional response, as identified by children and young people, was guided by reoccurring themes across the 12 studies:

- continuity of professional involvement – where children and young people found a variation in the consistency of professional support
- professionals' attitude towards children and young people – when negative professional–child relationship impacts on effective response
- understanding of safeguarding role – young people expressed confusion over the professional role
- child sexual exploitation and child trafficking – 2 studies sought the voice of the child, where some children and young people felt that there were issues with police response, age assessment and awareness among professionals.

The following evidence indicates effective professional response to working with children and young people, cited in 4 studies (Cossar 2011 +; Rees 2010 +; Richardson-Foster 2012 +; Stanley 2009 -).

- Form relationships with children, social workers. Need to be knowledgeable about child development and the impact of abuse and maltreatment.
- The relationship was seen as pivotal by children and young people, 1 based on feeling they were being listened to and there was time to build effective relations.
- Have good skills in communicating with children. This should be an important focus of social work training and continuing professional development.
- Speak directly with the child and young person, offering practical support.
- Acknowledge, with sensitivity, the difficult experience for the child.

1. Continuity of professional involvement

Five of the studies (Cossar 2011 +; Franklin 2013 +; Rees 2010 +; Skinner 2009 +; Stanley 2009 -) found that both young people and adult survivors reported they had a poor response from professionals in respect to the abuse they were experiencing.

Cossar (2011 +), Franklin (2013 +), Rees (2010 +) and Stanley (2009 -) note that some children had trusting relationships with professionals (social workers and police officers), yet some reported having minimal relationship and response, seeing them rarely or only in meetings, and often having to repeat their story. Young people described feeling let down if they were given 'false expectations by professionals about what might happen' (Rees, 2010+, p57) or 'social workers not keeping their promises' (Stanley, 2009 -, p61).

Rees (2010 +) reported that some young people also described their frustration at having infrequent meetings with their social worker – for example, not getting contact details or if their worker was constantly unavailable. One young person remarked: 'Sometimes when I ring [my social worker] she never rings us back' (p55).

In the Skinner (2009 +) study of Sexual Assault Referral Centres' response to sexual assault, young people commented on the Criminal justice process and the police officer in charge of the case. They stated that their experience was that the police officer was never available or would not get back to them. The lack of information about their case was considered to be negative, especially coupled with a negative outcome in court.

Four studies (Children's Commissioner 2015 -; Franklin, 2013 +; Harper 2005 +; Smeaton 2013 -) explored experiences of accessing support of children and young people. Adult survivors of child abuse responded in a UK poor-quality mixed-method study (Children's Commissioner 2015 -) with feelings of 'disappointment and distress' regarding their contact with statutory services. Some reported they had not been believed. One participant said: 'I had a few sessions of counselling via my GP, this was awful, limited to a couple of sessions and actually … left me feeling let down yet again. It took me many years to search for a local charity who were absolutely amazing, without them I most probably would not be here today' (p78).

In a survey of adult survivors of childhood abuse in Ireland (McGee et al. 2002 +), the majority were satisfied with the response they received from the police, but a third were dissatisfied with their treatment by medical professionals.

In the Franklin (2013 +) study, which explored trafficked young people and adult survivors, it is reported that they had benefited from therapeutic support after

experiencing serious mental health issues as a result of the exploitation. Two studies (Harper 2005 +; Smeaton 2013 -) identified young people's viewpoints on effective practice, which include:

- more services where young people 'can just turn up' (Smeaton 2013 -, p82).
- outreach work can be valuable
- developing a positive relationship with professionals where they feel they are being listened to
- seeing the professional regularly, where the young people are kept informed.

2. Professionals' attitude towards children and young people

Five studies (Cossar 2011 +; Harper 2005 +; Richardson-Foster 2012 +; Skinner 2009 +; Stanley 2009 -) reported that young people had negative experiences of professionals' response to them. In most studies (Harper 2005 +; Richardson-Foster 2012 +; Skinner 2009 +; Stanley 2009 -), professionals were police officers, who responded to young people with cynical and distrustful attitudes, which were perceived by young people to be 'biased', 'judgemental' and 'ignorant' (Richardson-Foster 2012 +). Conversely, Skinner (2009 +) noted that generally young people reacted positively towards police officers who wore plain clothes, were female (due to disclosure of sexual assault) and had unmarked police cars.

Cossar (2011 +) reported that young people expressed negative aspects of having social work involvement, which included intrusion, increased stress within the family and having to deal with stigma. An effective response was where social workers demonstrated sensitivity to how difficult the experience was for the young people.

McGee et al.'s (2002 +) study found that 11% of adult survivors of child abuse felt that medical professionals had made them feel 'responsible for their experience of sexual violence' (p141).

3. Understanding of safeguarding role

Cossar's (2011 +) study reports a varying degree of children and young people's understanding of child protection and concluded that understanding was age related. Cossar rated children's understanding into 3 categories: minimal, partial and clear

understanding, with most of those having a clear understanding being in the older age group. The majority of the children were categorised as having a partial understanding. Children with a partial understanding of child protection sometimes had a detailed account of part of the process. They had some overview of the system but could not give a coherent account. They often relied on parents and siblings for information. Some of the children whose families were involved in court proceedings had a better understanding of the court process than they did of other aspects of child protection. Children with a clear understanding were older and all of them had attended a child protection meeting.

Some children found it difficult to talk to their social workers because they felt pressured by the social worker asking questions, or said that the social worker twisted what they said. Few children saw reports or assessments and it was rare for the young person to have a chance to discuss the report with the social worker. A small minority of children were aware of different ways their views could be given to the meeting. Most of the children who attended the meetings found them difficult because they were being asked awkward questions in front of their parents. Few felt they were listened to and spoke about decision-making at the meeting. Not many children had seen their child protection plans.

Rees (2010 +) noted that a number of young people expressed confusion over the professional's role in the safeguarding process. One young person commented '... to be honest having a social worker kind of confused me a bit, she was asking all these complicated questions and I was 11 at the time, thinking, what? What's that mean? (Laughs) Really confusing' (p56). Children and young people that were looked-after appeared to have a clearer idea of the child protection process than those respondents who had a shorter social care involvement.

4. Child sexual exploitation (CSE) and child trafficking

Four studies (Beckett 2013 ++; Franklin 2013 +; Harper 2005 +; Smeaton 2013 -) explored specifically young people's experiences of professionals responding to CSE and child trafficking. General themes arose from professional awareness and the experiences of age assessment.

Two studies (Beckett 2013 ++; Smeaton 2013 -) that sought the experiences of young people and adult survivors who had been sexual exploited reported that the current service response and in the general sense the system is still in its early stages. Young people emphasised the importance of raising awareness among young people and for professionals through training. (Professional response will be explored further in section 3, where both studies sought the experiences of professionals.)

Franklin (2013 +) and Harper (2005 +) reported mixed experiences of trafficked children and young people who had undergone an age assessment, in order to receive statutory support. Many trafficked children undergo multiple age assessments, which some practitioners thought were highly problematic for this group of children. Age assessments were often taking place in police stations and in some cases they were being undertaken by social workers who were making pre-judgements. Children reported in Franklin's (2013 +) study that they were often not believed during age assessments and the questioning of them made it difficult to have good relationships with their social worker. Some children had their age wrongly identified and had been sent to adult prisons or detention centres, or had been placed in adult accommodation, placing them in a very vulnerable position.

Harper's (2005 +) study notes that age disputes can be a barrier to trafficked and exploited young people accessing protection. Barriers to the police helping trafficked young people included lack of resources and difficulties in gathering intelligence on perpetrators. Note that the Harper study was written in 2005 and practice may have changed, however when compared with a more recent study (Franklin 2013 +) it would appear that age assessments are still challenging for young people.

Caregiver experiences of professionals' responding to child abuse

Description of evidence

We found a good-quality UK qualitative study (Ghaffar et al. 2012 ++) and a moderate quality UK qualitative study (Skinner 2009 +) that looked at caregivers' experiences of professionals responding to child abuse.

Narrative summary

The study by Ghaffar et al. (2012 ++) provided a useful framework, which distinguishes between:

- communication and engagement – with families' and caregivers' experiences of the continuity of professional engagement and attitude
- case management – with families' and caregivers' experiences of child protection statutory assessment and intervention, and the accessibility of information.

This framework has guided the thematic analysis of the papers, which is divided into the broad areas of 'communication and engagement' and 'case management'.

1. Communication and engagement

Parents in Ghaffar's (2012 ++) study reported negative experiences when a professional held a stigmatising attitude towards them. The examples were generally directed towards social workers for making them feel stigmatised if they had a history of substance misuse. Most parents considered positive experiences when social workers had good listening skills and were open and clear about agency involvement.

In both studies, parents reported experiences of being kept informed and continuous engagement. The experiences reported in Ghaffar (2012 ++) were that most families had experienced a change in social worker, which made them feel uncomfortable having to divulge personal information to a new worker. The study suggested that parents recognised the supportive and practical function of social services – as a couple who disagreed with agency involvement remarked: 'they had [baby's] best interest at heart ... they did the job properly' (p900). The study notes that parents considered intervention effective if social workers spent time with the children. Additional social worker qualities included good organisation and reliability.

Skinner's (2009 +) study aimed to understand the experiences of young people who reported a sexual offence to a police service in England and included interviews with 5 mothers and a father. The Sexual Assault Referral Centre provides a case-tracking service for survivors, keeping them informed through the criminal justice system, and some parents were positive about this. One mother commented: 'Any time the lads

[alleged offenders] went in, they would call back and they wrote a letter saying that they had been released on bail and their case was still pending and they would have go back to the police station on such and such a date. And they were really spot on!' (p132).

Other parents were angered having to chase information and, in some cases, a survivor found out the alleged offender had been released from a friend of a friend or the local newspaper.

2. Case management

Ghaffar et al. (2012 ++) found that most parents felt that social workers did not acknowledge the level of stress experienced during the assessment process. Families stated they concealed information from professionals for fear of consequences such as domestic abuse, mental health issues or drug taking, which might impact on the removal of their children. Most parents felt the deficit model of assessment was disempowering. A parent recalls the assessment report submitted to a case conference: 'There was nothing positive, it was all bad. When you're in a room full of professionals it's not very nice' (p898). Conversely, 1 mother recalls her strengths being recognised and this empowered her and improved her morale: 'they told me ... I've got potential to do it. I've just got to get my mind in the right place' (p898).

In Ghaffar's study, parents were asked about their experiences of being part of case conference and child protection plan process. Generally, parents commented on their daunting experience of the case conference, emphasised by feeling unable to present their perspective. For example, 1 parent said that case conferences were 'very heavy and quite draining … I used to feel ill when I came out' (p898). On the other hand, several parents mentioned the positive experience of the conference chair who had been supportive.

The study asked if parents agreed (n=19) or disagreed (n=17) with their child protection plan decision. Reasons cited for agreeing were that parents felt able to access more services or, in domestic abuse instances, safety. However, parents who disagreed felt that they did not fully understand the safeguarding responsibilities of professionals.

Parents reported not being routinely given written information about child protection procedures, which impacted on their ability to compete on equal terms. Some parents commented on not understanding the information provided. As 1 parent recalls, 'It was all in double Dutch. I attempted to read it, but it didn't make sense, it was like reading a doctor's prescription' (p897). In some instances, parents did not recognise the seriousness or purpose of the child protection processes (Ghaffar et al. 2012 ++).

Practitioner views of what helps and hinders recognition

Description of evidence

We found 16 studies that sought practitioner views of what helps and hinders effective response to child abuse. The characteristics of the studies are shown in Table 48.

Table 48. Study characteristics – practitioner views of what helps and hinders recognition

Author/date	Study methods	Quality rating and reason (for poor studies)	Type of abuse
Beckett et al. (2013)	Eleven focus groups with 76 professionals (plus individual interviews with 150 young people; 8 single-sex focus groups with 38 young people)	++	Gang-associated sexual violence and exploitation
Burgess et al. (2011)	Twelve focus groups with 114 practitioners and survey responded to by 47 local authorities	- There is little information about consent of participants or what geographical region data is collected, so caution to generalise. Conclusions are difficult to see as reliable because the analysis is 'somewhat reliable'. In addition, no ethical consideration. Furthermore, the findings are relatively brief, including anecdotal accounts of unspecified respondents, so the challenge is contextualising data.	Child neglect

Devaney (2008)	Qualitative interviews with 28 professionals	+	Long-term complex needs with families who are in the child protection system
Franklin and Doyle (2013)	The study conducted 18 telephone interviews with multi-agency professionals, i.e. social care managers, frontline workers, solicitors and voluntary sector staff, to assess mechanisms in place to support trafficked or suspected trafficked children and the role of professionals; 30 head of local safeguarding children's boards completed an online survey to assess the multi-agency response in the context of best practice in child protection and safeguarding	+	Trafficked children
Hackett (2013)	Qualitative interviews with 6 school nurse professionals.	+	Perception of roles in relation to child protection
Harper and Scott (2005)	Qualitative interviews with 90 professionals	+	Child sexual exploitation, with small amount of information in relation to trafficking
Izzidien (2008)	Semi-structured interviews with managers and practitioners (n=30) and 2 focus groups	- The study had a poor research design with little information or context on where the data has been collected. The professionals are cited as mainly NSPCC domestic abuse services staff in England and Wales	Domestic violence
Kazimirski et al. (2009)	In-depth interviews with 40 professionals across 4 case study local authorities	+	Forced marriage

McNaughton Nicholls et al. (2014)	Qualitative research with 50 professionals (41 interviews and 9 online responses)	+	Child sexual exploitation
Pearce (2011)	Data was collected through 9 focus groups with a generic sample of practitioners (n=72) from 3 locations in England.	++	Child trafficking
Pearce et al. (2009)	Qualitative interviews with 72 practitioners, and review of case files of 37 trafficked children	++	Child trafficking
Richardson-Foster et al. (2012)	Qualitative interviews with 30 police officers (plus 19 children and young people)	+	Domestic violence
Smeaton (2013)	The study aimed to collect data from conducting telephone interviews with 27 practitioners and surveying 28 voluntary sector projects working within the field of CSE and running away (plus interviews carried out with young people under the age of 16 (n=41) who experience running away and CSE)	- Survey of services is entirely of voluntary sector services, and it is unclear whether interviewed professionals represented a wider range of services – the voluntary sector perspective of the research is not highlighted or justified in the research methodology. Little consideration in the findings of how contextual and demographic factors shape participant responses	Sexual exploitation
Stalker et al. (2010)	Qualitative interviews with 10 'key informants'	- Sample generally representative of Scotland (n=8), so caution to generalise. Poor empirical study – there is no information on data analysis, collection or how findings are contextualised	The needs and rights of disabled children in child protection
Taylor (2014)	In-depth interviews with 21 practitioners which included use of a critical incident technique methodology, and 5 focus groups with a total of 40 representatives child protection committees	+ Findings representative of Scotland	Disabled children and child protection
Wirtz (2009)	Data was collected through interviews and focus	+	Child trafficking

	groups with professionals (n=15), and the analysis of 34 case studies (interviews with trafficked migrant children (n=8))		

Five studies examined professional practice in relation to neglect and non-specified forms of child abuse. These were 1 poor quality mixed methods study (Burgess 2011 -), 1 poor quality qualitative study (Stalker 2010 -) and 3 moderate quality qualitative studies (Devaney 2008 +; Hackett 2013 +; Taylor 2014 +).

Four studies examined professional practice in relation to child sexual exploitation. These were 1 good quality qualitative study (Beckett et al. 2013 ++), 2 moderate quality qualitative studies (Harper and Scott 2005 +; McNaughton 2014 +) and 1 poor quality qualitative study (Smeaton 2013 -). It should be noted that the Harper and Scott study, though of relatively good quality, is somewhat dated, and it is likely that professional practice will have changed since 2005. McNaughton (2014 +) was specifically considering the sexual exploitation of boys and men.

Four studies explored professional practice in relation to child trafficking; 3 were good quality (Wirz 2009 ++; Pearce et al. 2009 ++; Pearce 2011 ++) and 1 was of moderate quality (Franklin 2013 +).

One moderate quality study explored professional practice in relation to forced marriage (Kazimirski 2009 +). Two moderate quality studies explored professional practice in relation to domestic abuse (Izzidien 2008 +; Richardson-Foster et al. 2012 +).

Narrative summary

Neglect and non-specified forms of abuse

There were coherent findings across studies examining professional practice in relation to an effective response to child neglect and non-specified forms of abuse, with 4 main themes emerging.

1. Professionals' relationship and communication skills (Devaney 2008 +; Hackett 2013 +; Stalker 2010; Taylor 2014 +)

Devaney (2008 +) reported findings from professionals that indicated the way they approach and treat families is a critical factor determining the effectiveness of their work with complex cases. This can be hindered by confusion or disagreement about the purpose of social workers' involvement with families. Three studies referenced the importance of professional confidence in working with families: Hackett (2013 +) cited the need for confidence, varied communication tools and techniques and listening skills as important for taking forward child protection concerns; Stalker (2010 -) and Taylor (2014 +) found that professionals can lack confidence in communicating with disabled children and, as a result, focus on engaging parents instead of children.

2. Multi-agency working (Burgess 2011 -; Devaney 2008 +; Stalker 2010 -; Taylor 2014 +)

Four studies reported professionals' views that there is a need for better working relationships between agencies to safeguard children. Professionals in the Burgess (2011 -) study thought that there can be lack of focus when multiple agencies are working with 1 family. This finding supports the view that professionals need to have a better understanding of each other's roles and responsibilities and agreement about outcomes to be achieved (Burgess 2011 -; Devaney 2008 +; Stalker 2010 -). There is also a need for open and regular communication that goes beyond simply sharing information (Devaney 2008 +; Taylor 2014 +).

3. Assessment and decision-making (Devaney 2008 +; Taylor 2014 +)

The Devaney study (2008 +) highlighted the importance of gathering an in-depth picture of the family relationships and social needs, noting that case note information content and quality can vary significantly and that there can be a 'tendency to provide a descriptive account of the events rather than a considered analysis' (quote from social work manager). Both the Devaney (2008 +) and Taylor (2014 +) studies highlighted professionals' anxieties about, and lack of confidence in, making decisions with the Devaney study indicating that this is a particular issue for non-social work staff.

4. Resources (Burgess 2011 -; Stalker 2010 -)

Resources were identified as a barrier to effective professional practice by 2 studies with particular concerns relating to: the impact of ring-fenced funding on provision for children with disabilities (Stalker 2010 -); inequality of access to support for families in rural areas (Burgess 2011 -; Stalker 2010 -) and challenges associated with high organisational turnover and restructures (Burgess 2011 -).

Child sexual exploitation (CSE)

There were coherent findings across 4 studies examining professional practice in relation to an effective response to child sexual exploitation, with 2 main themes emerging.

1. Multi-agency working (Beckett 2013 ++; Harper and Scott 2005 +; McNaughton Nicholls et al. 2014 +; Smeaton 2013 -)

Smeaton (2013 -) reported that professionals mentioned the importance of collecting and sharing information, particularly when young people move across areas, and that the failure to do this in some places hindered responses to young people who experience running away and CSE. An effective practice response was creating joint working measures and creating a culture of shared agency responsibility in safeguarding.

Beckett (2013 ++) cited a barrier for responding effectively to CSE where agencies work ‘in silo’. Consequently professionals reported that typically agencies are practising separately and not strategising together to work effectively which consequently affects information-sharing and partnership working.

Harper and Scott (2005 +) conveyed that professionals identified that there was no clear lead on CSE and a lack of clarity regarding the remit between child protection units; community safety units; Sapphire teams; local borough police; CID; missing persons units; public protection police; and the child abuse prevention units (note, this may well have changed since 2005).

McNaughton Nicholls et al. (2014 +) reported the effectiveness of co-location for an increase of referrals for boys and young men affected by CSE. Professionals noted that there were existing, strong multi-agency working practices around CSE and that these provided an opportunity for CSE practitioners to educate other professionals.

Professionals reported 3 forms of practice, which they thought were effective in improving response for boys and young men at risk of CSE:

- gender-neutral educational materials
- providing training for professionals on male victims
- co-location of CSE specialist practitioners with statutory agencies.

3. Criminal justice response to CSE (Harper 2005 +; McNaughton 2014 +; Smeaton 2013 -)

Harper (2005 +) and Smeaton (2013 -) explore issues in terms of the way the criminal justice system responds to CSE. Smeaton (2013 -) reports that both professionals and young people find being part of the CSE investigation difficult, and commented that police can often give 'mixed messages' and make young people feel criminalised (p69).

Harper (2005 +) reports that there is a difficulty achieving prosecutions, partly due to over-reliance on young people to press charges and give evidence. The study also reports that professionals struggle to tackle cases of CSE if young people do not cooperate, finding it especially difficult to engage with older teenagers.

Child trafficking

Four studies exploring child trafficking (Franklin 2013 +; Pearce et al. 2009 ++; Pearce 2011 ++; Wirtz 2009 ++) explored what professionals thought the barriers might be to responding to children who had been trafficked.

1. Awareness of trafficking

All studies reported that a general lack of awareness of trafficking meant some children were not properly protected, supervised, accommodated and supported, and went missing. Pearce (2011 ++) coined the term 'culture of disbelief' – where practitioners are unaware of indicators of trafficking and find it difficult to believe a child has been trafficked. The misplaced belief that a child can consent to being trafficked confused practitioners and can result in the child being overlooked (Pearce 2011 ++).

2. Child trafficking toolkits and National Referral Mechanism (NRM) guidance (Franklin 2013 +; Pearce 2011 ++)

Franklin (2013 +) reports that professionals find child trafficking toolkits and NRM guidance on trafficking helpful but some felt there was little understanding of how those indicators should be incorporated in assessment processes, to predict risk and as a way of determining the most appropriate services for a child. Additionally, the NRM process was seen as frustrating and did not provide support to a trafficked child.

Pearce (2011 ++) reports that professionals who do receive training and have theoretical knowledge of trafficking struggle to apply this in practice due to limited experience. Effective practice would be where practitioners have a good awareness of indicators of trafficking, which may include young people involved in criminal behaviour.

3. Access to mainstream services and specialist services (Pearce 2009 ++; Wirtz 2009 ++)

Two good quality studies report the value to children and young people who have been trafficked accessing both specialist and mainstream services to support their needs.

- Interpreters. The Pearce (2009 ++) study notes that practitioners highlighted the importance of interpreters who had been trained to understand that young people's accounts of trafficking may be affected by ongoing threats from their traffickers.
- Safe accommodation. Practitioners also thought that existing local authority accommodation was not well equipped to support trafficked children, including the availability of emergency placements for those who have just arrived in the country (Pearce 2009 ++).
- Legal. Young people may need additional support at ages 16 to 18 when their legal status in the UK may start to come into question (Pearce 2009 ++).
- Mental health services. Young people needed to be supported to access mainstream health provision, and mental health provision, and to stay in

education. Some western talking therapies might not be culturally appropriate (Wirtz 2009 ++).

Forced marriage

The study examining professional practice in relation to forced marriage (Kazimirski et al. 2009 +) identified that the quality and nature of effective response was hindered by the factors examined below.

Professionals reported that responses to cases of forced marriage were primarily considered to be part of domestic violence services, although responses to young people under 18 required a child protection response. Child protection responses were generally less clearly articulated that responses via the domestic violence services route. A typical response might be, after a child has gone missing from education for more than 21 days:

- school writes to local authority education and welfare team
- they carry out checks with housing, children's services and benefits agencies and may conduct a home visit
- if child is abroad, case is referred to forced marriage unit
- if child not abroad, case dealt with by children's services.

Quality and nature of response depended on the following factors.

- Capacity of partner agencies – due to lack of resources and reported high turnover of staff in statutory children's services and schools.
- Taking forced marriage seriously – priority attached to forced marriage across partner agencies.
- Cultural sensitivity – there was a perception that some statutory agencies thought forced marriage was beyond their remit as it is a 'cultural issue' (p43) or considered to be a private family matter.
- Compartmentalisation/culture of referral – the study reports a perceived tendency for agencies to want to 'refer on' cases of forced marriage, rather than respond themselves.
- Attitudes/perceptions of the victim – respondents saw part of their role as encouraging young people to recognise the risks they were facing.

- Differences in partners' expertise – respondents reported variable levels of understanding and awareness across different agencies, including awareness of what voluntary sector support services were available.
- Differences in professional practices and norms – particularly between the statutory and voluntary sectors. This included differences in the way that cases were drawn to the attention of services, and also the fact that the voluntary sector tended to seek solutions which maintain the family structure, which was not always possible for services operating within statutory frameworks.

Domestic abuse

Two studies exploring domestic abuse (Izzidien 2008 +; Richardson-Foster et al. 2012 +) reported what professionals thought the barriers might be to responding to children who had been affected by domestic abuse.

Izzidien's (2008 +) study collected evidence from practitioners working with South Asian women and children affected by domestic abuse and explored 'cultural' barriers that hinder effective response. The impact of shame and honour on South Asian young people was reported by practitioners and managers who spoke about the families' position within the wider context of the community. One service manager said, 'I think the South Asian community is programmed from birth to know that there are things you don't say outside the house, and domestic abuse is one of them' (p22). Practitioners reported that children who were born into domestic abuse felt that it was a normal pattern of life so didn't always report incidents and often felt a sense of isolation. In some instances, there was a lack of awareness or information available to offer support, and when young people did reach out, they did not want professionals to act. (Note the study is 8 years old, and practice might have changed.)

Richardson-Foster et al. (2012 +) collected evidence from both police officers and children about potential factors that hinder effective professional response to children affected by domestic abuse.

- Staff approach and relationship skills with children and young people and families/caregivers:

- Some police officers expressed reservations and reluctance about speaking to children directly, that it was not their role to speak to children at incidents, due mainly to a lack of confidence or skills in talking to children. They considered that expertise in talking to children resided with those officers who worked in specialist child protection posts.
- Generally, police viewed children and young people as figures on the sidelines of domestic violence incidents. In denying children a role in the experience of domestic violence, police officers ran the risk of colluding with parental claims that children were unaware of and unaffected by such violence.

- Resources:
  - A reluctance to engage with children's needs in the absence of resources was reinforced by operational procedures that militated against in-depth exploration of need – for example, performance targets ensuring a rapid response as a priority to a domestic violence call could lead to them dashing from 1 incident to the next with little opportunity to engage with the individuals involved, missing the potential for communication with the child.

Economics

No economic analysis or modelling was undertaken for this review question.

Evidence statements

ES152	**ES152. Children, young people and adult survivors' experiences of building relationships with professionals** There is a moderate amount of mixed quality evidence comprising 4 moderate quality UK qualitative studies (Cossar 2011 +; Franklin 2013 +; Rees 2010 +; Skinner 2009 +) and 1 poor quality UK qualitative study (Stanley 2009 -) that children and young people do not always have consistent, continuous support from professionals. This can have a negative impact on their ability to develop trusting, effective relationships with professionals.
ES153	**ES153. Children, young people and adult survivors' experiences of accessing support when they need it** There is a moderate amount of evidence of mixed quality evidence comprising 2 moderate quality UK qualitative studies (Franklin 2013 +; Harper 2005 +), 1 moderate quality Irish study (McGee et al. 2002 +), 1 poor quality UK qualitative study (Smeaton 2013 -) and 1 poor quality UK mixed methods study (Children's Commissioner 2015 -) that children and young people's experiences of accessing help, including therapeutic services, varied considerably. In particular, they reported: not being

	believed; not being able to speak to professionals when they needed to; and having to repeat their story several times
ES154	**ES154. Children, young people and adult survivors' experiences of professionals' attitudes towards them** There is a moderate amount of mixed quality evidence comprising 4 moderate quality UK qualitative studies (Cossar 2011 +; Harper 2005 +; Richardson-Foster 2012 +; Skinner 2009 +), 1 moderate quality Irish study (McGee at al. 2002 +) and 1 poor quality UK qualitative study (Stanley 2009 -) that young people who had negative experiences with professionals became cynical and distrustful. Evidence suggests an effective response is characterised by professionals being sensitive to how difficult the experience for the young person can be and thinking through every aspect of their meeting with them.
ES155	**ES155. Children, young people and adult survivors' experiences of understanding the safeguarding role** There is a small amount of mixed quality evidence comprising 2 moderate quality UK qualitative studies (Cossar 2011 +; Rees 2010 +) that young people vary in their understanding of child protection process. In addition, generally the age of the child or young person impacts on their depth of understanding. Evidence suggests that looked-after children and young people have a clearer idea of child protection processes than those with a shorter social care involvement.
ES156	**ES156. Children, young people and adult survivors' experiences of the professional response to child sexual exploitation** There is some mixed quality evidence comprising 1 good quality UK qualitative study (Beckett 2013 ++) and 1 poor quality UK qualitative study (Smeaton 2013 -) that young people recognise that the CSE system is still in the early stages, and there is a need for more awareness of it among professionals so they can respond appropriately.
ES157	**ES157. Children, young people and adult survivors' experiences of the professional response to child trafficking** Two moderate quality UK qualitative studies (Franklin 2013 +; Harper 2005 +) show that young people have a negative experience of practitioners responding to them as trafficked children due to age assessments. Young people who are not believed during an age assessment can feel vulnerable. Often they are not able to access appropriate services.
ES158	**ES158. Caregiver experiences of professionals communication and engagement when responding to child abuse** There is evidence from 1 good quality UK qualitative study (Ghaffar 2012 ++) that parents and caregivers have experienced practitioners as stigmatising and lacking empathy. This has caused them negative experiences, along with having to repeat their story when they get a new practitioner. Parents had positive experiences when practitioners were: good listeners; were open about how different agencies would be involved; and when they provided practical support.
ES159	**ES159. Caregiver experiences of professionals' communication and engagement responding to children who have experienced sexual assault** There is evidence from 1 moderate quality UK qualitative study (Skinner 2009 +) that parents appreciated good communication and an update on their child's case.

ES160	**ES160. Caregiver experiences of professionals case management when responding to child abuse** There is evidence from 1 good quality UK qualitative study (Ghaffar 2012 ++) that parents and caregivers have a varied experience of child protection procedures. Parents have a negative experience if the practitioner does not acknowledge the level of stress caused, and does not provide accessible information that parents understand.
ES161	**ES161. Practitioner views on relationship-building and communication skills** There is evidence from 3 moderate quality qualitative studies (Devaney 2008 +; Hackett 2013 +; Taylor 2014 +) and 1 poor quality qualitative study (Stalker 2010 -) that practitioners' ability to build relationships, and communicate with families is of paramount importance, and that they need to be confident and skilled in this respect.
ES162	**ES162. Practitioner views on communicating with disabled children** There is evidence from 1 poor quality qualitative study of professionals working with disabled children (Stalker 2010 -) that where professionals can work skilfully with the child, using games, toys and other methods, this can facilitate communication.
ES163	**ES163. Practitioner views on interagency working** There is evidence from 2 moderate quality qualitative studies (Devaney 2008 +; Taylor 2014 +), 1 poor quality qualitative study (Stalker 2010 -) and 1 poor quality mixed method study (Burgess 2011 -) to indicate the importance of good interagency working in delivering an effective response to abuse or neglect. In particular, this includes: building a shared understanding of different agencies' roles and remits; more regular interagency communication and more sophisticated data-sharing to include analysis, rather than just provision of information.
ES164	**ES164. Practitioner views on assessment and decision-making** There is evidence from 1 moderate quality qualitative study (Devaney 2008 +) that it is important to gather an in-depth picture of family relationships and social needs as part of assessment and decision-making. There is evidence from 2 moderate quality studies indicating the importance of building professionals' confidence to make decisions about the child, particularly non-social work professionals (Devaney 2008 +; Taylor 2014 +).
ES165	**ES165. Practitioner views on assessment and decision-making in respect of disabled children** There is evidence from 1 moderate quality UK qualitative study (Taylor 2014 +) of disabled children and child protection to suggest that interagency working facilitates assessment and decision-making. The same study found that barriers to effective practice in this regard included: lack of specialist knowledge about impairments and support requirements; lack of ability to respond to children's particular communication needs throughout the process; fear of 'getting it wrong'; complex family situations; and information being held in different places, causing delays.
ES166	**ES166. Practitioner views on resource-related barriers to providing an effective response** There is evidence from 2 poor quality UK studies (1 mixed method study by Burgess 2011 -; and 1 qualitative study by Stalker 2010 -) that funding restrictions and organisational change can impede effective provision.

ES167	**ES167. Practitioner views on geographical barriers to providing an effective response** There is evidence from 1 poor quality mixed-method study (Burgess 2011 -) that families in rural areas can find it particularly difficult and costly to reach services and that they therefore can be particularly isolated.
ES168	**ES168. Practitioner views on barriers to the response of child sexual exploitation** There is evidence from a good quality UK qualitative study (Beckett et al. 2013 ++) and a moderate-quality UK qualitative study (Harper and Scott 2005 +) that agencies working in isolation and not developing strategy together can be a barrier to responding to CSE. This is because it hinders them sharing information effectively and, as a result, limits partnership working. Additionally, practitioners do not think there is clarity about the remit of different agencies or who should lead on CSE. It should be noted, however, that practice is likely to have changed since this report was written.
ES169	**ES169. Practitioner views on what helps recognition of child sexual exploitation** There is evidence from 1 moderate quality UK qualitative study (McNaughton Nicholls et al. 2014 -) and 1 poor quality UK qualitative study (Smeaton 2013) that, for practitioners, effective practice means putting measures in place to enable joint working measures and create a culture of shared responsibility between each agency involved in safeguarding. Evidence on 1 undisclosed area suggests that practitioners report positive experiences of co-locating specialist CSE workers with statutory agencies to educate and provide training to other professionals on male victims of CSE.
ES170	**ES170. Practitioner views on the criminal justice response to CSE** There is evidence from 1 moderate-quality (Harper, 2005 +) and 1 poor quality qualitative study (Smeaton 2013 -) to indicate the difficulty in the criminal justice system's response to CSE. In particular, this includes: police criminalising the young person; achieving prosecution because of an over-reliance on the young person; and professionals' difficulty working young people who do not cooperate.
ES171	**ES171. Practitioner views on child trafficking toolkits and the National Referral Mechanism guidance in response of child trafficking** There is a small amount of evidence from 1 good quality UK qualitative study (Pearce 2011 ++) and 1 moderate quality UK qualitative study (Franklin 2013 +) that practitioners consider current toolkits and guidance helpful, but there exist challenges where practitioners who receive theoretical knowledge of trafficking can struggle to apply it in practice due to limited experience.
ES172	**ES172. Practitioner views on effective response to supporting children and young people who have been trafficked** There is a small amount of evidence from 2 good quality UK qualitative study (Pearce et al. 2009 ++; Wirtz 2009 ++) that practitioners consider that effective response to trafficked children should include access to specialist, trained interpreters, safe accommodation, legal support and mental health services.
ES173	**ES173. Practitioner views on what hinders professional response of forced marriage**

	There is evidence from 1 moderate quality UK qualitative study (Kazimirski et al. 2009 +) that practitioners perceive the following to be barriers to responding to forced marriage: capacity of partner agencies; taking forced marriage seriously; cultural sensitivity; compartmentalisation/culture of referral; the attitudes/perceptions of the victim; differences in partners' expertise; and differences in professional practices and norms.
ES174	**ES174. Practitioner views on what hinders response of domestic abuse in South Asian Communities** There is evidence from 1 moderate quality UK qualitative study (Kazimirski et al. 2009 +) that practitioners perceive the following to be barriers to responding to domestic abuse in South Asian communities: shame and honour; children feeling isolated; children not knowing about support services.
ES175	**ES175. Practitioner views on what hinders responding to children affected by domestic abuse** There is evidence from 1 moderate quality UK qualitative study (Richardson-Foster et al. 2012 +) that some police officers report an uncertainty on responding to children during an incident of domestic abuse. The barriers were cited as a lack of confidence and skill in speaking to children directly, and resource pressure demands, reinforced by operational procedures. Sometimes there was not time to effectively respond to children.

Included studies for these review questions

Beckett H, Brodie I, Factor F et al. (2013) 'It's wrong … but you get used to it' - A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England. London: Office of the Children's Commissioner for England

Burgess C, Daniel B, Scott J et al. (2012) Child neglect in 2011: an annual review by Action for Children in partnership with the University of Stirling. Watford: Action for Children

Children's Commissioner (2015) Protecting children from harm: a critical assessment of child sexual abuse in the family network in England and priorities for action. London: Office of the Children's Commissioner for England

Cossar J, Brandon M, Jordan, P (2011) 'Don't make assumptions': children's and young people's views of the child protection system and messages for change. London: Office of the Children's Commissioner

Devaney J (2008) Inter-professional working in child protection with families with long-term and complex needs. Child Abuse Review 17: 242-61

Franklin A and Doyle L (2013) Still at risk: a review of support for trafficked children. London: The Children's Society

Ghaffar W, Manby M, Race T (2012) Exploring the experiences of parents and carers whose children have been subject to child protection plans. British Journal of Social Work 42: 887-905

Hackett A (2013) The role of the school nurse in child protection. Community Practitioner 86, 26-9

Harper Z and Scott S (2005) Meeting the needs of sexually exploited young people in London. London: Barnardo's

Izzidien S (2008) 'I can't tell people what is happening at home': domestic abuse within South Asian communities – the specific needs of women, children and young people. London: NSPCC

Kazimirski A, Keogh P, Kumari V et al. (2009) Forced marriage prevalence and service response. London: Natcen

McGee H, Garavan R, de Barra MBJ et al. (2002) The SAVI report: sexual abuse and violence in Ireland. Dublin: The Liffey Press in association with Dublin Rape Crisis Centre, 1-392

McNaughton Nicholls C, Harvey S, Paskell C (2014) Gendered perceptions: what professionals say about the sexual exploitation of boys and young men in the UK. London: Barnardo's

Pearce J (2011) Working with trafficked children and young people: complexities in practice. British Journal of Social Work 41, 1424-40

Pearce J, Hynes P, Bovarnick S (2009) Breaking the wall of silence: practitioners' responses to trafficked children and young people. London: NSPCC

Rees G, Gorin S, Jobe A et al. (2010) Safeguarding young people: responding to young people 11 to 17 who are maltreated. London: The Children's Society

Richardson-Foster H, Stanley N, Miller P et al. (2012) Police intervention in domestic violence incidents where children are present: police and children's perspectives. Policing & Society 22, 220-34

Skinner T and Taylor H (2009) 'Being shut out in the dark'. Feminist Criminology (4)2: 130-50

Smeaton E (2013) Running from hate to what you think is love: the relationship between running away and sexual exploitation. Ilford: Barnardo's and Paradigm Research

Stalker K, Green Lister P, Lerpiniere J et al. (2010) Child protection and the needs and rights of disabled children and young people: a scoping study: abridged report. Glasgow: University of Strathclyde

Stanley N, Miller P, Richardson Foster H (2012) Engaging with children's and parents' perspectives on domestic violence. Child and Family Social Work 17, 192-201

Taylor J, Stalker K, Fry D et al. (2013) Disabled children and child protection in Scotland: investigation into the relationship between professional practice, child protection and disability. Scotland: Scottish Government Social Research

Wirtz L (2009) Hidden children: separated children at risk. London: Children's Society

3.10 Organisational factors in addressing child abuse and neglect

Introduction to the review question

This question was based on a systems approach to professional practice, as applied to child protection practice by, for example, Munro (2005) and Fish et al. (2008). This suggests that the quality of professional practice is shaped not just by the knowledge and skills of the individual, but also by the organisational context. The aim of this

question was therefore to assess what organisational factors support and hinder effective multi-agency working and professional judgement.

The evidence reviewed for this question comprised mixed methods and qualitative studies. Of the 10 included studies, 1 was a good quality mixed methods study and 1 was a poor quality mixed methods study. The remainder were qualitative studies with either children and young people, caregivers or professionals. Of the qualitative studies, 1 was rated as good quality (++), 5 were rated as moderate quality (+) and 2 were rated as poor quality (−).

Common methodological flaws in the poor quality, and some of the moderate quality studies, included: insufficient consideration and reporting of ethics procedures, including obtaining informed consent; limited information regarding methodology including sampling, data collection and analysis; and little consideration of context or diversity of opinion between participants in some studies. Some of these limitations may reflect the fact that a number of these papers are 'grey' literature published by charities and campaigning organisations, rather than peer-reviewed studies.

Review questions

21. What organisational factors support and hinder effective multi-agency working including supporting good professional judgement?

Question 21 also included material relevant to the following questions:

1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

Summary of the review protocol

The protocol sought to identify studies that would assess what organisational factors support and hinder effective multi-agency working and professional judgement. Study designs that were included for this question were process evaluation, ethnographic and observational studies of practice and analyses of serious case review data.

Full protocols can be found in Appendix A.

Population

Children and young people (under 18) who are experiencing, or have experienced abuse or neglect, and/or their caregivers and families.

Practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and their families and caregivers. For example, social workers, health professionals, those working in education, voluntary sector providers.

Intervention

Not applicable.

Setting

All settings where early help, recognition, assessment and response to child abuse and neglect may take place, including:

- children's own homes
- out-of-home placements including friends and family care, private fostering arrangements, foster care, residential care and secure accommodation
- primary and secondary health settings
- schools and colleges
- secure settings for children and young people (including young offender institutions)
- childcare settings
- police stations
- voluntary sector settings, including sports and youth clubs.

Outcomes

Experience and views of children, young people and their families; incidence of abuse and neglect; experience and views of adult survivors of child abuse and neglect; quality of parenting and parent–child relationships, including quality of attachment; children and young people's health and wellbeing; parents' health and wellbeing; service outcomes.

See Appendix A for full protocols.

How the literature was searched

Electronic databases in the research fields of social care, health, social sciences and education were searched using a range of controlled indexing and free-text search terms based on the themes a) child abuse or neglect (including: physical abuse, emotional abuse, sexual abuse, neglect, sexual exploitation, fabricated/induced illness(es), forced marriage, child trafficking and female genital mutilation (FGM)); and b) the processes of the care pathway (including: recognition, assessment, early help, response and organisational processes).

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations, and trials registries were undertaken to capture literature that might not have been found from the database searches.

Economic evidence was searched for as part of the single search strategy, and included searching within the economic databases the NHS Economic Evaluation Database (NHS EED) and the Health Economic Evaluations Database (HEED).

Guideline Development Group members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

The search was restricted to human studies in the English language and published from 2000. However, the Guideline Committee agreed to only use evidence from 2004. This was on the basis of it being the year of publication of the Children Act 2004 which amended the legal framework responding to concerns about the abuse and neglect of children.

The bibliographic database searches were undertaken between November 2014 and December 2014. The website searches were conducted between August 2014 and October 2014. Update searching of the bibliographic databases searches took place in April 2016.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs. Outputs were initially screened against an exclusion tool informed by the overall parameters of the scope.

Studies that were included after the initial screening stage were assigned to questions. They were then screened on title and abstract against the specific criteria for those questions. For question 20 these were as follows:

- country (study is not from Europe, Israel, Australia, Canada, USA, New Zealand)
- evidence type (study is not process evaluation, ethnographic and observational studies of practice, analyses of serious case review data or a systematic review of the above)
- population (not children and young people (under 18) or are at risk of, are experiencing or have experienced abuse or neglect, or their parents or carers OR practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and their families and caregivers. For example, social workers, health professionals, those working in education, voluntary sector providers)
- topic (study does not have a specific focus on what organisational factors support and hinder multi-agency working).

For questions 1 and 2 these were as follows:

- country (study is not from the UK)
- evidence (not an empirical study including qualitative studies, qualitative components of effectiveness and mixed methods studies, survey studies or systematic reviews of these study types)

- population (population is not children and young people who are at risk of, are experiencing, or have experienced abuse or neglect; their caregivers and families; adult survivors of abuse or neglect; practitioners working with children and young people who at risk of, are experiencing, or have experienced abuse and neglect, and/or their caregivers and families)
- topic (study does not relate to the process of recognising abuse and/or neglect, the process of assessment, services providing early help, services providing intervention following abuse or neglect).

Screening on title and abstract identified 426 papers of potential relevance to this question. Due to the high numbers of potential studies, a decision was taken to include UK studies only, those with a clear reference to the topic in the title or abstract, and studies published from 2011 onwards (last 5 years) (n=143). As a result of full text screening we identified 10 papers which had specific relevance to aspects of professional practice and ways of working in relation to early help.

See Appendix B for full critical appraisal and findings tables.

Narrative summary of the evidence

Practitioner views and evidence from serious case reviews

Description of evidence

We found 8 studies which sought practitioner views of what organisational factors help and hinder effective multi-agency work and professional judgement, and 2 serious case review syntheses containing evidence relevant to organisational factors. The characteristics of the studies are shown in Table 49.

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Table 49. Study characteristics – practitioner views and evidence from serious case reviews

Author/ date	Study methods	Agency	Quality rating and reason (for poor studies)	Type of abuse
Beckett (2013 ++)	Qualitative study comprising 11 focus groups with 76 professionals (other data collection with CYP not relevant to research question)	Representation from fields of social care, education, health, policing and the justice system, specifically working within the gangs and sexual exploitation/sexual violence	++	Child sexual exploitation and gang associated violence
Berelowitz et al. (2013 +)	Qualitative study based on phase 2 of the inquiry included semi-structured interviews and focus groups (n=41 professionals) and site visits) (n=62 agencies) (other data collection with CYP not relevant to research question)	Voluntary organisations, police, schools and colleges, local safeguarding children's boards, multi-agency groups, government agencies, health, children and young people's services and trainers	+	Child sexual exploitation
Brandon et al. (2013 +)	Serious case review synthesis. Serious case reviews of 5 individual and interlinking studies into child maltreatment and neglect	Multiple agencies	+	Child neglect and maltreatment

Brodie and Pearce (2012 -)	Qualitative study. Focus group held with 27 practitioners	Child protection committees with representatives from health, the police, CSC and third sector organisations	- Due to no reporting on the data collection or analysis of the seminar, findings are not rich. There is no contextualising of participants or ascribing which finding was said by whom. Consequently, conclusions are 'somewhat adequate'	Child sexual exploitation
Crockett et al. (2013 ++)	Qualitative study. Qualitative interviews with MASH staff only relevant (phase 3) (Data collection has other phases which are not relevant)	Police, education, CSE, health	++	Child protection
Mortimer et al. (2012 -)	Qualitative study. Online survey (qualitative), focus groups, semi-structured interviews	School staff, education professionals and wider school staff and external partners from 4 schools in a wide geographical area	- Lack of methodological details	Child protection
Rouf et al. (2012 +)	Qualitative study. Semi-structured interviews and diary-keeping with staff	From the community mental health team (CMHT) – community psychiatric nurses, psychologists, social workers, psychiatrists, named nurse for CP	+	Child neglect
Smeaton (2013 -)	Qualitative study. Telephone interviews with 27 professionals	These professionals had a variety of roles including: programme managers, project managers/coordinators, senior practitioners and	- Survey of services is entirely of voluntary sector	Child sexual exploitation and running away

	who work with children who experience running away and CSE Survey of 28 projects working with young people experiencing CSE and/or running away	project support workers. The majority of the 28 projects are based in the voluntary sector, with 2 projects describing themselves as a voluntary sector project based within the statutory sector	services, and it is unclear whether interviewed professionals represented a wider range of services – the voluntary sector perspective of the research is not highlighted or justified in the research methodology. Little consideration in the findings of how contextual and demographic factors shape participant responses	
Taylor et al. (2013 +)	Qualitative study. Research comprised 'in-depth' interviews with 21 practitioners which included use of a critical Iicident technique methodology, and 5 focus groups with child protection committees. From the interviews with practitioners, 34 practice examples were developed	The roles of the practitioners involved are not clear. The research report states that 'from each local authority area, potential participants were contacted from social work, education, police, voluntary organisations and health with practice experience of responding to at least two child protection cases involving a disabled child' (p14)	+	Child protection relating to disabled children
Vincent and Petch (2012 +)	Serious case review synthesis. Analysis of	Multiple agencies	+	Child neglect and maltreatment

	serious case review data			

Four studies discussed potential organisational factors hindering effective multi-agency working in relation to child sexual exploitation. These were 1 good quality qualitative study (Beckett 2013 ++), 1 moderate quality qualitative study (Berelowitz et al. 2013 +), and 2 poor quality qualitative studies (Brodie and Pearce 2012 -; Smeaton 2013 -). One moderate quality study explored professional practice in relation to children with disabilities (Taylor et al. 2013 +). The remaining studies considered practice in relation to general child protection issues relating to all forms of abuse and neglect (Brandon et al. 2013 +; Crockett et al. 2013 ++; Mortimer et al. 2012 -; Rouf et al. 2012 +; Vincent and Petch 2012 +).

The evidence is collated from numerous agencies with representatives from the following: CSC staff, police, schools and colleges, local safeguarding children's boards, multi-agency groups, government agencies, health, children and young people's services and trainers; and from the community mental health team (CMHT) – community psychiatric nurses, psychologists, social workers, psychiatrists, named nurse for child protection.

Narrative summary

We have grouped the findings into the following sections:

- the national system
- local multi-agency systems
- individual agency systems.

An overview of the themes identified across the papers is shown in Table 50.

Table 50. Framework of themes – organisational factors which support and hinder effective multi-agency work and professional judgement

Paper	Agency and type of abuse	Organisational context							Resource constraints
		National systems	Local systems				Individual agency systems		Resources including staff shortages
		National processes of child protection	Leadership and strategy	Joint working procedures	IT systems	Co-location	Supervision	Culture	
Beckett (2013 ++)	Multiple agencies CSE and gangs		x	x	x				x
Berelowitz et al. (2013 +)	Multiple agencies CSE and gangs	x	x	x		x			x
Brandon et al. (2013 +)	Multiple agencies, Child neglect	x			x		x	x	
Brodie and Pearce (2012 -)	Multiple agencies CSE	x				x	x		
Crockett et al. (2013 ++)	MASH staff Child protection			x	x	x		x	x
Mortimer et al. (2012 -)	Education practitioners	x		x				x	x

	Child protection								
Rouf et al. (2012 +)	Community mental health team Child neglect								
Smeaton (2013 -)	Specialist Voluntary sector staff CSE and running away			x					x
Taylor et al. (2013 +)	Child protection with disabled children						x	x	x
Vincent and Petch (2012 +)	Multiple agencies Child neglect	x	x	x	x		x	x	

National system

Five studies (Berelowitz et al. 2013 +; Brandon et al. 2013 +; Brodie and Pearce 2012 -; Mortimer et al. 2012 -; Vincent and Petch 2012 +) examined factors in relation to national processes of the child protection system in terms of what could potentially help and hinder effective multi-agency working and professional judgement. The overarching themes were as follows.

1. Legislation

Brodie and Pearce's (2012 -) study of practice in relation to child sexual exploitation found that practitioners felt that existing legislation lacked sufficient force, and was not resulting in the conviction of those involved in the sexual exploitation of children and young people. This was linked to the other perceived gaps in the system – if, for example, practitioners were not sufficiently trained or supported, then the disruption of abusive networks would not take place. This finding has not been captured in an evidence statement, as it is outside the scope of this guideline.

2. Interagency working and involvement of the courts

In Brandon et al.'s (2013 +) analysis of serious case reviews, the authors highlight working relationships between the courts and the wider interagency safeguarding process as a barrier to effective practice. The study reports that, in many serious case reviews, court proceedings were seen as separate from interagency working, and that the resulting breakdowns in communication may have led to children being put at further risk of harm.

3. The distinction between child in need and child in need of protection

The serious case review analyses conducted by both Brandon et al. (2013 +) and Vincent and Petch (2012 +) also highlight the potential confusions arising from the distinction between child in need and child in need of protection arrangements. These included the following.

- A lack of attention to issues of protection when operating under child in need processes (Vincent and Petch 2012 +).

- Confusion among practitioners between ‘child in need’ procedures and ‘child protection’ procedures as a continuum, leading to a substantial gulf in practitioners’ approaches (Brandon et al. 2013 +).
- There was also confusion over the terminology used for multi-agency meetings, including ‘child in need’, ‘common assessment framework’ and ‘team around the child’ meetings, compounded by a lack of clarity in terms of who takes responsibility for such meetings, lack of clear arrangements for chairing and taking minutes, and lack of structure for the meetings. This led to many meetings being unclear in their focus, with a lack of any definitive action plan or accountability for following through on agreements, resulting in inadequate assessments being undertaken or repeated partial assessments which never fully appraised the situation of the children (Brandon et al. 2013 +).

Local multi-agency systems

1. Leadership and strategic planning

Two studies made reference to the impact of leadership and strategic planning with specific reference to child sexual exploitation (Beckett 2013 ++; Berelowitz et al. 2013 +).

Berelowitz et al. (2013 +) report that professionals found a lack of clear and committed leadership regarding child sexual exploitation among some of the most senior decision-makers at local level. Without local and national leadership, dedicated professionals worked in a vacuum. An effective example of good practice was where professionals adopted a ‘whole-school approach’ to protecting children and young people in schools.

Similarly, Beckett (2013 ++) reports that practitioners found inadequate partnership working and cross-fertilisation of learning between gangs and sexual exploitation/sexual violence initiatives.

2. Multi-agency joint working procedures

Six studies (Beckett 2013 ++; Berelowitz et al. 2013 +; Crockett et al. 2013 ++; Mortimer et al. 2012 -; Smeaton et al. 2013 -; Vincent and Petch 2012 +) explored

the impact of local joint working procedures on effective multi-agency working and professional judgement.

Three studies (Beckett 2013 ++; Berelowitz et al. 2013 +; Smeaton et al. 2013 -) looked particularly at this issue in relation to child sexual exploitation. The following barriers were identified.

- Lack of joint strategy. No strategic planning in some Local Safeguarding Children Boards (LSCBs) in relation to child sexual exploitation. The absence of a joint strategy resulted in differing approaches and conflicting priorities between local agencies (Berelowitz et al. 2013 +).
- Silo working. Silo working across different agencies in relation to child sexual exploitation and strands of work, and a lack of knowledge of how one's practice fits within wider relevant strategies and operational initiatives resulted in a lack of information-sharing between agencies (Beckett 2013 ++).

However, 1 study (Smeaton et al. 2013 -) identified local procedures in which missing person reports (MISPER) are used across agencies as an effective way to identify children who are running away and may be at risk of child sexual exploitation.

One study examined the experience of education professionals in safeguarding (Mortimer et al. 2012 -), and found that practitioners cited difficulties in not knowing who to contact. For example, 'we did try to produce a directory of local services/agencies but it keeps changing so hard to keep up. Would be helpful to have one' (Member of staff, inner city school, Midlands, Mortimer et al. 2012 -).

One study analysing serious case review reports (Vincent and Petch 2012 +) highlighted inadequate referral procedures regarding health involvement in safeguarding, stating that in some cases 'There were not clear pathways and protocols in place for appropriate and timely referral of possible physical abuse cases for specialist investigation and paediatric forensic examination' (p76).

One evaluation of a local multi-agency safeguarding hub (MASH) (Crockett et al. 2013 ++) found that professionals cited clear local protocols as facilitating effective multi-agency working.

3. IT systems

Four studies (Beckett 2013 ++; Brandon et al. 2013 +; Crockett et al. 2013 ++; Vincent and Petch 2012 +) mentioned the impact of IT systems and different agency databases on effective multi-agency working and professional judgement. The common themes arising were as follows.

- Multiple databases. For example, in Crockett (2013 ++), many interviewees commented on the multitude of IT systems, notably when an individual professional did not have access to a database they needed or had to travel to a different site to access information from a database that was not available in the MASH. Barriers to good practice caused by multiple IT systems within the health sector were also noted in Vincent and Petch (2012 +).
- Quality of records. One analysis of serious case reviews (Vincent and Petch 2012 +) found that electronic records could hinder practice in that records were not sufficiently detailed and analytical, and contained inaccuracies and inconsistencies.
- Critical use of database. An over-reliance on electronic recording systems and proformas, and working strictly to criteria rather than critically thinking about cases (Brandon et al. 2013 +).

One study looking specifically at practice in relation to child sexual exploitation (Beckett et al. 2013 ++) noted that the lack of 'read across' between different databases could potentially lead to risks being overlooked.

4. Co-location and multi-agency safeguarding hubs (MASHs)

Three studies (Berelowitz et al. 2013 +; Brodie and Pearce 2012 -; Crockett et al. 2013 ++) explored the impact that co-location and MASHs have on effective multi-agency working and professional judgement, with 2 considering this specifically in relation to child sexual exploitation (Berelowitz et al. 2013 +; Brodie and Pearce 2012 -). The Crockett et al. (2013 ++) study reports that the core features of the London MASH were as follows.

- 'All notifications relating to safeguarding and promoting the welfare of children to go through the hub.

- A co-located team of professionals from core agencies (Children's Social Care, Police, Health, Education, Probation, Housing and Youth Offending Service) delivering an integrated service with the aim to research, interpret and determine what is proportionate and relevant to share.
- The hub is fire walled, keeping MASH activity confidential and separate from operational activity and providing a confidential record system of activity to support this.
- An agreed process for analysing and assessing risk, based on the fullest information picture and dissemination of a suitable information product to the most appropriate agency for necessary action.
- A process to identify potential and actual victims, and emerging harm through research and analysis' (p11).

Berelowitz et al. (2013 +) found that practitioners reported that various agencies and services were working in isolation to tackle child sexual exploitation and viewed child sexual exploitation through its own lens. They failed to work together to arrive at a comprehensive picture of the problem in their local area. An example of good practice was the establishment of a multi-agency forum (such as the MASH or co-locating professionals) to combine the expertise and resources of several bodies in order to identify and refer children and young people who are at risk of child sexual exploitation, as some sexually exploited children and young people face dangers from multiple sources (Berelowitz et al. 2013 +; Brodie and Pearce 2012 -).

Crockett et al. (2013 ++) specifically focused on the early impact of MASH, and suggests effective communication across agencies. Practitioners involved in the study reported that MASH facilitated high quality communication and information-sharing. MASH was seen to facilitate better communication, which ensured high quality information was 'gathered in line with risk to children' (MASH professional, p44). One interviewee commented: 'You know people you are talking to and can have informal conversations which can get a lot more done' (MASH professional, p44). There was a clearer understanding of 'jargon' used by different agencies.

Co-location was seen to be promoting relationship-building, mutual professional understanding and the development of trust. One interviewee commented 'having professionals in one room, you establish a level of trust, understanding which may

not have been quite as strong when you're all in separate areas' (MASH professional, p42). Having all agencies in a single secure space was seen to be saving on traveling times.

Individual agency systems

1. The culture of the organisation

Five studies (Brandon et al. 2013 +; Crockett et al. 2013 ++; Smeaton 2013 -; Taylor et al. 2013 +; Vincent and Petch 2012 +) discussed the culture of the organisation and its influence on professional practice. The common themes arising were as follows.

- Professionalism. Vincent and Petch's (2012 +) analysis of serious case reviews identified a lack of 'professionalism' and critical thinking among practitioners as a factor. This included people not taking their safeguarding roles seriously, or relinquishing their responsibility once they had referred the case on to others and not ensuring that actions did take place. They report that this lack of professionalism could extend to the underlying culture of whole teams, resulting in inadequate assessments, or a failure to follow cases through from assessment to actions and outcomes (Vincent and Petch 2012 +).
- Procedure-driven. Brandon et al.'s (2013 +) analysis of serious case reviews identified that practice can be hindered by 'procedure-driven', uncritical practice, which may have arisen because of professionals focusing exclusively on their own areas of practice, again taking a narrow, problem-based approach to working with children and families.
- Different agencies' response to safeguarding. Some interviewees commented on the contrasting way other agencies respond to safeguarding concerns. For example, 1 police officer described himself and colleagues 'as being trained to make rapid decisions' and compared this to 'social workers who take a more "softly softly" approach that takes longer' (Crockett et al. 2013, p.41). Other interviews described the police as 'having their own way of doing things' (Crockett et al. 2013 ++, p41). One study also highlighted a clash of working cultures between the voluntary and statutory sectors (Smeaton 2013 -).

Effective approaches to organisational culture were addressed in Crockett et al.'s (2013 ++) study in which practitioners reported that MASH was facilitating positive working relationships, despite the different professional cultures, and would foster a better understanding of roles and responsibilities.

Vincent and Petch (2012 +) suggest that an effective means of addressing a lack of focus on the child by all agencies, including adult services, is by developing a reflective, questioning practice culture in order to avoid drift and the operation of the 'rule of optimism'. This is suggested to be where practitioners feel confident to challenge parents or medical opinion as well as each other.

2. Supervision

Four studies (Brandon et al. 2013 +; Smeaton 2013 -; Taylor et al. 2013 +; Vincent and Petch 2012 +) explored the importance supervision has on effective multi-agency working and professional judgement.

Brandon et al. (2013 +) suggest that critical reflection, peer review and supervision are important factors in supporting effective multi-agency working, and allow professionals time to stop and think, rather than simply be driven by 'the needs of the system'. Vincent and Petch (2012 +) also identify support and supervision as important factors in good quality practice.

Smeaton's (2013 -) study of practice in relation to child sexual exploitation reports that practitioners felt they needed appropriate and effective support and supervision to address and minimise impact upon them; also staff and team professional development, and time to reflect upon their practice: '... That is really important in terms of meeting our needs as practitioners [because] it's really challenging, and emotionally challenging, work … Being skilled up and having time to process is really important; having time to think about our work and not having panic knee-jerk responses to things' (p79).

Taylor et al.'s (2013 +) study of practice in protection of disabled children reports that practitioners require a safe intergency reflective space be created for discussing and learning from examples of practice related to child protection and disability.

3. Resource constraints

Six studies (Beckett 2013 ++; Berelowitz et al. 2013 +; Crockett et al. 2013 ++; Mortimer et al. 2012 -; Smeaton 2013 -; Taylor et al. 2013 +) mentioned resource constraints in relation to what helps and hinders effective multi-agency working and professional judgement. The issues cited were as follows.

- Funding cuts. Impact of financial cuts on the provision of services, both in terms of which services remained and decreasing capacity to engage in any long-term supportive work, a key to any sustainable response. Under-resourcing hampered a planned intergency systemic response long term. For example, 1 professional commented: '… young people don't understand the fact that things are commissioned or funded for a set period of time … – this week we're running; next week we're not running ever again because our funding's finished' (Beckett et al. 2013 ++, professional focus group E, p48).
- Staff shortages impacted on workload. Several practitioners commented in Crockett's (2013 ++) study on the increase in referrals and services to their MASH, where staff could not meet the demand. In 1 instance, an interviewee commented upon heavy workloads after seeing a senior social worker being so busy and working late, which increased stress (MP17, p51). In contrast, 1 borough had good resourcing and that meant they could turn around most of the reports within the timescales as risks and dangers were highlighted at the earliest opportunity (MP15, p51).
- Resources for specialist projects. Professionals recommended that there would be more funding available for work with young people running away and experiencing child sexual exploitation. Professionals identified that practice was facilitated by use of voluntary funds, rather than when money was strictly ring-fenced for particular purposes (Smeaton 2013 -).
- Additional support. The current fiscal climate of fewer resources without diminishing demand is a potential challenge to disabled children and their families who may require additional support (Taylor et al. 2013 +).

Economics

No economic analysis or modelling was undertaken for this review question.

Evidence statements

ES176	**ES176. Organisational factors that hinder effective multi-agency work and professional judgement – influence of national factors** There is a small amount of moderate quality evidence from 2 moderate quality UK serious case review syntheses (Brandon et al. 2013 +; Vincent and Petch 2012 +) that misunderstandings relating to the difference between child in need and child in need of protection processes can hinder effective multi-agency working. This includes confusion over the terminology for multi-agency meetings, a lack of clarity in terms of who takes responsibility, lack of structure, and accountability for developing and following through with an action plan. One study also highlights that several serious case reviews have highlighted poor coordination between courts and wider multi-agency safeguarding processes (Brandon et al. 2013 +).
ES177	**ES177. Practitioner views on organisational factors that hinder effective multi-agency work and professional judgement – leadership and strategic planning in relation to child sexual exploitation and gangs** There is a small amount of evidence from 1 good quality UK qualitative study (Beckett et al. 2013 ++) and 1 moderate quality UK qualitative study (Berelowitz et al. 2013 +) that practitioners have identified a lack of clear local leadership on child sexual exploitation and gangs, including a failure to cross-fertilise learning across initiatives, as a barrier to effective multi-agency working in this area.
ES178	**ES178. Organisational factors that help and hinder effective multi-agency work and professional judgement – local multi-agency protocols** There is a moderate amount of mixed quality evidence from 2 good quality UK qualitative studies (Beckett et al. 2013 ++; Crockett et al. 2013 ++), 1 moderate quality UK qualitative study (Berelowitz et al. 2013 +) and 1 poor quality UK qualitative study (Smeaton et al. 2013 -) that practitioners perceive local multi-agency protocols as influencing the effectiveness of practice. A lack of joint strategic planning was perceived as hindering practice, and leading to 'silo working'. Procedures such as routine use of missing person's reports were perceived as helping practice. One serious case review analysis (Vincent and Petch 2012 +) highlighted a lack of clear procedures for health involvement in safeguarding as a feature of serious case reviews.
ES179	**ES179. Organisational factors that help and hinder effective multi-agency work and professional judgement – IT systems** There is a small amount of good quality evidence from 2 good quality UK qualitative studies (Beckett et al. 2013 ++; Crockett et al. 2013 ++) that IT systems influence multi-agency practice and professional judgement. Incompatibility of IT systems across agencies was perceived to hinder multi-agency working and professional judgement, including in relation to tackling child sexual exploitation. Two moderate quality serious case review syntheses (Brandon et al. 2013 +; Vincent and Petch, 2012 +) highlight poor quality recording and an over-reliance on electronic systems at the expense of critical thinking as barriers to good practice.

ES180	**ES180. Practitioner views on organisational factors that help and hinder effective multi-agency work and professional judgement – co-location** There is some evidence of mixed quality from 1 good quality UK qualitative study (Crockett et al. 2013 ++), 1 moderate quality UK qualitative study (Berelowitz et al. 2013 +) and 1 poor quality UK qualitative study (Brodie and Pearce 2012 -) that practitioners perceive that co-location influences multi-agency working and professional judgement. Factors identified as hindering multi-agency co-located working included different agency cultures, language and terminology and perception of risk thresholds. Factors identified as helping multi-agency working included combination of expertise and resources from various agencies, the opportunity to have informal discussions about cases, and the development of strong relationships based on professional understanding and mutual trust.
ES181	**ES181. Organisational factors that help and hinder effective multi-agency work and professional judgement – organisational culture** There is some evidence of mixed quality from 1 good quality UK qualitative study (Crockett et al. 2013 ++), 1 moderate quality UK qualitative study (Taylor et al. 2013 +) and 1 poor quality UK qualitative study (Smeaton 2013 -) that practitioners report organisational cultures as influencing multi-agency working. Cultural factors reported to hinder multi-agency work include differing cultures across agencies. Two moderate quality UK serious case review syntheses (Brandon et al. 2013 +; Vincent and Petch, 2012 +) report that features of serious case reviews included a culture in which safeguarding was not taken seriously and actions were not followed up, and practice being 'procedure driven'.
ES182	**ES182. Organisational factors that help and hinder effective multi-agency work and professional judgement – supervision** There is a small amount of evidence of mixed quality from 1 moderate quality UK qualitative study (Taylor et al. 2013 +) and 1 poor quality UK qualitative study (Smeaton 2013 -) that practitioners identify supervision as an important influence on the quality of multi-agency work and professional judgement. Two moderate quality UK serious case review syntheses (Brandon et al. 2013 +; Vincent and Petch 2012 +) also highlight supervision as an important factor in ensuring good quality practice.

Included studies for these review questions

Beckett H, Brodie I, Factor F et al. (2013) 'It's wrong … but you get used to it' - A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England. London: Office of the Children's Commissioner for England

Berelowitz S, Clifton J, Firmin C et al. (2013) 'If only someone had listened': Office of the Children's Commissioner's inquiry into child sexual exploitation in gangs and groups. London: Office of the Children's Commissioner for England

Brandon M, Sidebotham P, Bailey S et al. (2013) New learning from serious case reviews: a 2-year report for 2009 to 2011. London: Department of Education

Brodie I and Pearce J (2012) Exploring the scale and nature of child sexual exploitation in Scotland. Edinburgh: Scottish Government Social Research

Crockett R, Gilchrist G, Davies J et al. (2013) Assessing the early impact of multi agency safeguarding hubs (MASH) in London. London: London Councils, MASH and University of Greenwich

Mortimer J, North M, Katz A at al. (2012) You have someone to trust – outstanding safeguarding practice in primary schools. London: Office of Children's Commissioner

Rouf K, Larkin M, Lowe G (2012) Making decisions about parental mental health: an exploratory study of community mental health team staff. Child Abuse Review 21, 173-89

Smeaton E (2013) Running from hate to what you think is love: the relationship between running away and sexual exploitation. Ilford: Barnardo's

Taylor J, Stalker K, Fry D et al. (2013) Disabled children and child protection in Scotland: investigation into the relationship between professional practice, child protection and disability. London: Scotland. Scottish Government Social Research

Vincent S and Petch A (2012) Audit and analysis of significant case reviews. Edinburgh: The Scottish Government

3.11 Evidence to recommendations

This section of the guideline details the links between the guideline recommendations, the evidence reviews, expert witness testimony and the guideline committee discussions. Section 3.11.1 provides a summary of the evidence sources for each recommendation. Section 3.11.2 provides substantive detail on the evidence for each recommendation, presented in a series of linking evidence to recommendations (LETR) tables.

3.11.1 Summary map of recommendations to sources of evidence

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
1.1 Principles for working with children, young people, parents and carers	
Working with children and young people	
1.1.1 Take a child-centred approach to all work with children and young people; involve them in decision-making to the fullest extent possible depending on their age and developmental stage.	GC consensus
1.1.2 Use a range of methods (for example, using drawing, books or activities where appropriate) for communicating with children. Tailor communication to: • their age and developmental stage • any disabilities, for example learning difficulties or hearing and/or visual impairments • communication needs, for example by using communication aids or providing an interpreter (ensure the interpreter is not a family member).	ES162, expert witness, GC consensus
1.1.3 In all conversations with children and young people:	ES127, ES154, children and young people's expert reference group

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
• explain confidentiality and when you might need to share specific information, and with whom • be sensitive and empathetic • listen actively and use open questions • find out their views and wishes • use plain language and explain any technical terms • work at the child or young person's pace • give them opportunities to stop the conversation or leave the room, and follow up if this does happen • explain what will happen next and when.	
1.1.4 Make sure the child or young person is comfortable with the environment in which conversations are being held and ensure they have privacy if they want to discuss any worries.	ES140, children and young people's expert reference group, GC consensus
1.1.5 If your interaction with a child or young person involves touching them (for example, a medical examination) explain what you are going to do. For young people over 16, or children and young people who are under 16 but are Gillick competent, ask for their agreement first. If they do not agree and touching them is essential to their treatment, seek legal advice, unless the need for treatment is immediate. In all other cases respect their disagreement.	Children and young people's expert reference group, GC consensus
1.1.6 Produce a written record of conversations with children and young people and check that they agree with these (this could include both of you signing the record). Ensure their words are accurately represented, using their actual words if possible.	Children and young people's expert reference group
1.1.7 Share reports and plans with the child or young person in a way that is appropriate to their age and understanding.	ES153, children and young people's expert reference group

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
1.1.8 When working with children and young people, always do what you say you are going to do. If circumstances change and this is no longer possible, explain why as soon as possible, and offer alternative actions.	Children and young people's expert reference group
1.1.9 When working with children and young people, clearly explain how you will work together with them and ensure they do not have unrealistic expectations.	ES153, children and young people's expert reference group
1.1.10 Explain to the child or young person (if age appropriate) how and when they can contact you and what services are available out of hours. Give them contact details.	ES153, children and young people's expert reference group
1.1.11 Agree with the child or young person how and when you will contact them, bearing in mind safety issues such as whether a perpetrator of abuse may have access to a young person's phone. Agree what will happen if you contact them and they do not respond, for example following up with their nominated emergency contact.	ES153, children and young people's expert reference group
Working with parents and carers	
1.1.12 Aim to build good working relationships with parents and carers to encourage their engagement and continued participation. This should involve:	ES19, ES20, ES128, ES132, ES158, ES160, ES161

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
• actively listening to them • being open and honest • avoiding blame, even if parents may be responsible for the abuse or neglect • inviting, recognising and discussing any worries they have about specific interventions they will be offered • identifying what parents are currently doing well, and building on this • working in a way that enables trust to develop while maintaining professional boundaries • being reliable, and available as promised • keeping them informed, including explaining what information has been shared, and with whom • being clear about the issues and concerns that have led to your involvement • being clear about the legal context in which your involvement with them is taking place.	
Working with other practitioners	
1.1.13 Coordinate your work with practitioners in other agencies so that children, young people, parents and carers do not need to give the same information repeatedly.	ES153, ES158, children and young people's expert reference group
Critical thinking and analysis	
1.1.14 Think critically and analytically about cases and do not rely solely on protocols, proformas and electronic recording systems to support your professional thinking and planning.	ES179
1.2 Recognising abuse and neglect	
Children and young people telling others about abuse and neglect	
1.2.1 Recognise that children and young people who are being abused or neglected may find it difficult to tell someone for the first time because:	ES139, ES140, ES141, ES144, ES145, children and young people's expert reference group

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
• they may have feelings of shame, guilt and of being stigmatised • they may not always recognise their own experiences as abusive • they may be being coerced by (or may be attached to) their abuser • they may fear the consequences of telling someone, for example that the abuse might get worse, their family will be split up or they will go into care.	
1.2.2 Recognise that children and young people who are experiencing abuse or neglect may not acknowledge this when questioned, or may not want others to know.	ES139, ES140, ES141, ES144, ES145, children and young people's expert reference group
1.2.3 Recognise that children and young people may communicate their abuse or neglect indirectly through their behaviour and appearance (see NICE's guideline on child maltreatment and recommendations 1.2.12 to 1.2.45 in this guideline).	ES139, ES140, ES141, children and young people's expert reference group
1.2.4 Explore your concerns with children and young people in a non-leading way, for example by using open questions, if you are worried that they may be being abused or neglected.	ES147, children and young people's expert reference group
1.2.5 Avoid causing possible prejudice to any formal investigation during early conversations about abuse and neglect with children and young people. Follow guidance in the Ministry of Justice's Achieving best evidence in criminal proceedings.	ES147, children and young people's expert reference group
1.2.6 If a child or young person tells you that they have experienced abuse or neglect, explain to them whom you will need to tell, and discuss what will happen next and when. Avoid setting unrealistic expectations.	ES141, children and young people's expert reference group
Child risk factors for abuse and neglect	
1.2.7 For disabled children, be aware that their disability may increase the risk of abuse or neglect by their parents, carers or others, and make it harder to recognise. Also remember that disabled children may have many carers.	ES95

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
1.2.8 Recognise that both girls and boys can be sexually exploited, and that child sexual exploitation is not confined to a particular sexual orientation.	ES149, expert witness
Parental risk factors for abuse and neglect	
1.2.9 Consider abuse and neglect if a parent, carer, sibling or other adult in a child's household has 1 or more of the following risk factors: • They have substance misuse difficulties. • There is a history of domestic abuse. • They are emotionally volatile or have problems managing their anger. • They are experiencing mental health problems. The risk factors above may be compounded if the parent, carer, sibling or other adult in a child's household lacks support from family or friends.	ES106, ES108, ES112, ES115, ES117, ES121.
1.2.10 Recognise the following as risk factors for recurring or persistent child abuse and neglect: • the parent or carer does not engage with services • there have been 1 or more previous episodes of abuse or neglect • the parent or carer has a mental health or substance misuse problem • there is chronic parental stress • the parent or carer experienced abuse or neglect as a child. Recognise that neglect and emotional abuse are more likely to recur or persist than other forms of abuse.	ES107, ES113, ES116, ES118, ES120, ES122, ES123, GC consensus
1.2.11 Ensure that practitioners understand that risk factors can be interrelated, and that separate factors can combine to increase the risk of harm to a child.	ES27
General behavioural and emotional indicators of child abuse and neglect	

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
1.2.12 Consider current abuse and neglect if a child or young person displays, or is reported to display, either of the following that differs from what would be expected for their age and developmental stage (see boxes 1 and 2): • a marked change in behaviour or emotional state or • repeated, extreme or sustained emotional responses. Consider abuse and neglect even if these initially appear to be explained by a known stressful situation (for example, bereavement or parental separation).* Box 1. Examples of behaviour and emotional states • Being fearful or withdrawn, low self-esteem • Extreme distress • Wetting and soiling • Recurrent nightmares containing similar themes • Aggressive, oppositional behaviour • Withdrawal of communication • Lack of ability to understand and recognise emotions • Habitual body rocking • Indiscriminate contact or affection seeking • Over-friendliness to strangers, including healthcare practitioners • Excessive clinginess • Persistently seeking attention • Demonstrating excessively 'good' behaviour to prevent parental or carer disapproval • Failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed • Coercive controlling behaviour towards parents or carers • Very young children showing excessive comforting behaviours	Adopted from NICE guideline on child maltreatment, ES78, children and young people's expert reference group

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
when witnessing parental or carer distress. Box 2. Examples of emotional responses • Frequent rages at minor provocation • Distress expressed as inconsolable crying • Anger or frustration expressed as a temper tantrum in a school-aged child.	
1.2.13 Consider past (as well as current) abuse and neglect if a child or young person shows repeated, extreme or sustained emotional responses as described in 1.2.12.	Adopted from NICE guideline on child maltreatment
1.2.14 Consider current or past abuse and neglect if a child shows dissociation (transient episodes of detachment that are outside the child's control and that are distinguished from daydreaming, seizures or deliberate avoidance of interaction).*	Adopted from NICE guideline on child maltreatment
1.2.15 Consider current or past abuse or neglect if children or young people are showing any of the following behaviours: • substance or alcohol misuse • self-harm • eating disorders • suicidal behaviours • bullying or being bullied.	ES86, ES87, ES88, ES89, ES90, children and young people's expert reference group
1.2.16 Consider current or past abuse and neglect if a child or young person has run away from home or care.*	Adopted from NICE guideline on child maltreatment, children and young people's expert reference group
1.2.17 Consider current or past abuse and neglect if a child or young person is living in alternative accommodation without the justified agreement of their parents or carers.*	Adopted from NICE guideline on child maltreatment
1.2.18 Consider abuse and neglect if a child or young person regularly has responsibilities that interfere with the child's essential normal daily activities (for example, school attendance).*	Adopted from NICE guideline on child maltreatment
1.2.19 Consider current or past abuse and neglect if a child responds to a health examination or assessment in an unusual, unexpected or developmentally	Adopted from NICE guideline on child maltreatment

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
inappropriate way (for example, extreme passivity, resistance or refusal).*	
Sexual behavioural indicators of child maltreatment	
1.2.20 Suspect current or past abuse and neglect if a child or young person's sexual behaviour is indiscriminate, precocious or coercive.*	Adopted from NICE guideline on child maltreatment
1.2.21 Suspect abuse and neglect, and in particular sexual abuse, if a pre-pubertal child displays or is reported to display repeated or coercive sexualised behaviours or preoccupation (for example, sexual talk associated with knowledge, emulating sexual activity with another child).*	Adopted from NICE guideline on child maltreatment
1.2.22 Suspect sexual abuse if a pre-pubertal child displays or is reported to display unusual sexualised behaviours. Examples include: • oral–genital contact with another child or a doll • requesting to be touched in the genital area • inserting or attempting to insert an object, finger or penis into another child's vagina or anus.*	Adopted from NICE guideline on child maltreatment
Behavioural indicators of child neglect	
1.2.23 Suspect current or past abuse and neglect if a child repeatedly scavenges, steals, hoards or hides food with no medical explanation (for example Prader–Willi syndrome).*	Adopted from NICE guideline on child maltreatment
1.2.24 Suspect neglect if you repeatedly observe or hear reports of any of the following in the home that is in the parents or carers' control: • a poor standard of hygiene that affects a child's health • inadequate provision of food • a living environment that is unsafe for the child's developmental stage. Be aware that it may be difficult to distinguish between neglect and material poverty. However, care should be taken to balance recognition of the constraints on the parents or carers' ability to meet their	Adopted from NICE guideline on child maltreatment

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
children's needs for food, clothing and shelter with an appreciation of how people in similar circumstances have been able to meet those needs.*	
1.2.25 Suspect neglect if a child is persistently smelly and dirty. Take into account that children often become dirty and smelly during the course of the day. Use judgement to determine if persistent lack of provision or care is a possibility. Examples include: • child seen at times of the day when it is unlikely that they would have had an opportunity to become dirty or smelly (for example, an early morning visit) • if the dirtiness is ingrained.*	Adopted from NICE guideline on child maltreatment
1.2.26 Consider neglect if a child has severe and persistent infestations, such as scabies or head lice.*	Adopted from NICE guideline on child maltreatment
1.2.27 Consider neglect if a child's clothing or footwear is consistently inappropriate (for example, for the weather or the child's size). Take into account that instances of inadequate clothing that have a suitable explanation (for example, a sudden change in the weather, slippers worn because they were closest to hand when leaving the house in a rush) would not be alerting features for possible neglect.*	Adopted from NICE guideline on child maltreatment
Indicators of abuse and neglect: child development	
1.2.28 Consider neglect if a child displays faltering growth because of lack of provision of an adequate or appropriate diet.*	Adopted from NICE guideline on child maltreatment
1.2.29 Consider physical or emotional abuse or neglect if a child under 12 shows poorer than expected language abilities for their overall development (particularly in their ability to express their thoughts, wants and needs), which is not explained by other factors, for example speaking English as a second language.	ES80, ES93
Indicators of abuse and neglect: interactions between children and young people and parents or carers	

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
1.2.30 Consider neglect or physical abuse if a child's behaviour towards their parent or carer shows any of the following, particularly if they are not observed in the child's other interactions: • dislike or lack of cooperation • lack of interest or low responsiveness • high levels of anger or annoyance • seeming passive or withdrawn.	ES82, ES83, ES84, ES85
1.2.31 Consider emotional abuse if there is concern that parent– or carer–child interactions may be harmful. Examples include: • Negativity or hostility towards a child or young person. • Rejection or scapegoating of a child or young person. • Developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining. • Exposure to frightening or traumatic experiences, including domestic abuse. • Using the child for the fulfilment of the adult's needs (for example, in marital disputes). • Failure to promote the child's appropriate socialisation (for example, involving children in unlawful activities, isolation, not providing stimulation or education).*	Adopted from NICE guideline on child maltreatment
1.2.32 Suspect emotional abuse if the interactions observed in recommendation 1.3.31 are persistent.*	Adopted from NICE guideline on child maltreatment
1.2.33 Consider emotional neglect if there is emotional unavailability and unresponsiveness from the parent or carer towards a child or young person and in particular towards an infant.*	Adopted from NICE guideline on child maltreatment
1.2.34 Suspect emotional neglect if the interaction observed in recommendation 1.3.33 is persistent.*	Adopted from NICE guideline on child maltreatment
1.2.35 Consider abuse and neglect if parents or carers are seen or reported to	Adopted from NICE guideline on child maltreatment

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
punish a child for wetting and soiling despite practitioner advice that the symptom is involuntary.*	
1.2.36 Consider abuse and neglect if a parent or carer refuses to allow a child or young person to speak to a practitioner on their own when it is necessary for the assessment of the child or young person.*	Adopted from NICE guideline on child maltreatment
1.2.37 Recognise that excessive physical punishment constitutes physical abuse.	ES104
Supervision by parents and carers	
1.2.38 Suspect neglect if parents or carers persistently fail to anticipate dangers and to take precautions to protect their child from harm. However, take into account that achieving a balance between an awareness of risk and allowing children freedom to learn by experience can be difficult.*	Adopted from NICE guideline on child maltreatment
1.2.39 Consider neglect if the explanation for an injury (for example, a burn, sunburn or an ingestion of a harmful substance) suggests a lack of appropriate supervision.*	Adopted from NICE guideline on child maltreatment
1.2.40 Consider neglect if a child or young person is not being cared for by a person who is able to provide adequate care.*	Adopted from NICE guideline on child maltreatment
Providing access to medical care or treatment	
1.2.41 Consider neglect if parents or carers fail to collect or administer essential prescribed treatment for their child.*	Adopted from NICE guideline on child maltreatment
1.2.42 Consider neglect if parents or carers repeatedly fail to attend follow-up appointments that are essential for their child's health and wellbeing.*	Adopted from NICE guideline on child maltreatment
1.2.43 Consider neglect if parents or carers persistently fail to engage with relevant child health promotion programmes which include: • immunisation • health and development reviews • screening.*	Adopted from NICE guideline on child maltreatment
1.2.44 Consider neglect if parents or carers have access to but persistently fail to obtain NHS treatment for their child's dental caries (tooth decay).*	Adopted from NICE guideline on child maltreatment
1.2.45 Suspect neglect if parents or carers fail to seek medical advice for their child to	Adopted from NICE guideline on child maltreatment

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
the extent that the child's health and wellbeing is compromised, including if the child is in ongoing pain.*	
Supporting practitioners to recognise abuse and neglect	
1.2.46 Ensure all practitioners working in primary care can recognise and respond to child abuse and neglect. Ways to achieve this include: • training newly qualified doctors in risk factors for abuse and neglect, such as parental mental health problems, alcohol and substance misuse (and providing top-up training sessions every 6 months) • giving information to parents and newly qualified practitioners, for example about local resources such as children's centres and parenting groups • completing a standardised questionnaire to screen for risk factors • providing access to a social worker where possible.	ES18
1.2.47 Ensure practitioners working in community settings, including education, can recognise and respond to child abuse and neglect and are aware of child safeguarding guidance relevant to their profession, for example the Department for Education's Keeping children safe in education.	ES18, GC consensus
Recognising child trafficking	
1.2.48 Recognise that there are many reasons why children and young people may be trafficked other than for sexual exploitation. Other forms of exploitation include: • forced marriage • domestic servitude • working for low or no pay, or in illegal industries • being used for benefit fraud.	ES150, expert witness
1.2.49 Recognise that both girls and boys can be trafficked and that children and young people from the UK can be	ES150, expert witness

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
trafficked, as well as those from other countries.	
1.2.50 If you suspect a child or young person may have been trafficked: • ensure that concerns about their age and immigration status do not override child protection considerations • recognise that choosing an interpreter from the child's community may represent to them the community that has exploited them • aim to ensure continuity with the same interpreter, keyworker or independent advocate.	ES150, ES172, expert witness
1.3 Assessing risk and need in relation to abuse and neglect	
1.3.1 Practitioners leading the assessment should ensure that all significant adults, children and young people in the family are involved. This means: • finding out their views and wishes • taking time to understand family relationships and dynamics. Exceptions are adults who could affect the nature of a criminal investigation, for example in cases of sexual abuse, induced illness, serious physical abuse or neglect and forced marriage.	ES128, GC consensus
1.3.2 As part of the assessment, collect and analyse information about all significant people in the child's care environment. The assessment should include each person's: • family, personal, social and health history, and • experiences of being parented.	ES126, ES164
1.3.3 When assessing a child or young person for abuse and neglect, practitioners should:	ES127, GC consensus

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
• observe the child or young person • communicate directly with them • explore in a non-leading way any presenting signs of child abuse and neglect. Do not rely solely on information from the parent or carer in an assessment. See also recommendations 1.1.1 to 1.1.12 about working with children, young people, parents and carers.	
When assessing a child or young person follow the principles in recommendation 1.1.3 and also: • keep them involved and informed at every stage of assessment and decision-making • tailor communication to their specific needs (see recommendation 1.1.2) • reinforce that they have a right to talk about any abuse or neglect and to seek help.	ES127, ES143, children and young people's expert reference group
1.3.5 Provide training in communication skills to enable practitioners assessing children and young people to identify and interpret signs of abuse and neglect.	ES165
1.3.6 Practitioners should adopt an individualised approach to assessment that takes into account each child or young person's specific needs.	GC consensus
1.3.7 Communicate concerns honestly to families about child abuse and neglect, taking into account confidentiality. Think about what information should be shared, and with whom, to avoiding placing the child at risk of further harm.	ES128, ES132
1.3.8 During assessment, focus primarily on the child's needs but also remember to: • address both the strengths and weaknesses of parents and carers and acknowledge that parenting can change over time • focus attention equally on male and female parents and carers.	ES129
Developing a plan	

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
1.3.9 Analyse the information collected during assessment and use it to develop a plan describing what services and support will be provided. This should be agreed with the child and their family (also see recommendation 1.1.7). Analysis should include evaluating the impact of any risk factors.	ES130
Supporting practitioners to undertake good quality assessment	
1.3.10 Organisations should ensure that practitioners conducting assessment in relation to abuse or neglect of disabled children or young people can access a specialist with knowledge about those children and young people's specific needs and impairments.	ES165
1.4 Early help for families showing possible signs of abuse or neglect	
Home visiting programmes	
1.4.1 Consider a programme of home visits, lasting at least 6 months, for parents or carers at risk of abusing or neglecting their child or children. This includes parents or carers with previously confirmed instances of abuse and neglect.	ES1, ES2, ES3, ES4, ES5, EcES1, economic modelling
1.4.2 Identify parents and carers who would benefit from a programme of home visits during pregnancy or shortly after birth wherever possible.	ES1, ES2, ES3, ES4, ES5, EcES1

1.4.3 Ensure that the programme of home visits includes:
• support to develop positive parent–child relationships, including:
  ○ helping parents to understand children's behaviour more positively
  ○ modelling positive parenting behaviours
  ○ observing and giving feedback on parent–child interactions
• helping parents to develop problem-solving skills
• support for parents with substance misuse and mental health difficulties
• support for parents to access relevant services, including
	ES1, ES2, ES3, ES4, ES5, ES22, EcES1

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
healthcare, early years, educational services and other community services.	
1.4.4 Ensure that the programme of home visits is delivered by either a health or social care practitioner or another worker who has been trained in delivering that particular home visiting programme.	ES1, ES2, ES3, ES4, ES5, EcES1
Parenting programmes	
1.4.5 Consider a parenting programme for parents or carers at risk of abusing or neglecting their child or children. Tailor parenting programmes to the specific needs of the family (see recommendations 1.4.7 to 1.4.10).	ES6, ES7, ES8, ES9, ES14, ES15, EcES3
1.4.6 When selecting parenting programmes think about whether parents or carers would benefit from help to: • develop skills in positive behaviour management • address negative beliefs about the child and their own parenting • manage difficult emotions, including anger.	ES6, ES7, ES8, ES14, ES15, EcES3
1.4.7 Consider the Enhanced Triple P (attributional retraining and anger management) programme for mothers of children aged 2 to 7, who are experiencing anger management difficulties.	ES6, ES7, ES8, ES14, ES15, EcES3
1.4.8 Consider the Parents Under Pressure programme for mothers taking part in methadone-maintenance programmes.	ES6, ES7, ES8, ES14, ES1, EcES3
1.4.9 Consider a planned activities training programme, with or without mobile phone support, for vulnerable mothers (for example, those with a low level of education or income or aged under 18) of preschool children.	ES6, ES7, ES8, ES14, ES15, EcES3
1.4.10 For parents or carers who have substance misuse problems, include content in the parenting programme to help them address their substance misuse in the context of parenting.	ES6, ES7, ES8, ES14, ES15, EcES3
Supporting families	

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
1.4.11 Offer support to families as part of building helpful working relationships with them. This could include: • practical support, for example help to attend appointments and details of other agencies that can provide food, clothes and toys • emotional support, including empathy and active listening, and help to develop strategies for coping.	ES23, ES24
1.4.12 Give families information about local services and resources that they may find useful.	ES4
1.4.13 Ensure that all practitioners working at the early help stage: • understand the parental risk factors for child abuse and neglect (see recommendations 1.2.9 to 1.2.10) • are aware of the possibility of escalation of risk, particularly if family circumstances change.	ES27
1.4.14 Ensure that practitioners understand how to work with families as a whole in order to better support children and young people.	GC consensus
1.5 Response and support following abuse and neglect	
1.5.1 After making a child protection referral: • do not relinquish responsibility for the referral • follow up the referral • ensure action takes place. You should expect to hear back from children's social care whether or not action has been taken, and the timescale of this action. If there is no action, follow local escalation policies if needed.	ES181
1.5.2 Practitioners working with families in which a child is involved in statutory child protection processes should: • take part in case conferences and meetings about the child • have an initial meeting with relevant practitioners to agree roles,	ES181

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
responsibilities and ways of working, and to share information • build relationships with other practitioners working with that family • make sure all stakeholders can keep in touch with each other about the child • organise handovers if new staff members become involved • ensure actions are completed.	
Support for children and young people after abuse and neglect	
1.5.3 Ensure that all children and young people who have been abused or neglected are given a minimum of: • a safe place to live • an opportunity to be actively listened to and believed • support to explore aspects of their experience and express their feelings • early emotional support, including building emotional resilience and strategies for coping with symptoms such as nightmares, flashbacks and self-harm • support to reduce the risk of further abuse where appropriate, for example if a young person is at risk of sexual exploitation.	GC consensus
Children affected by domestic abuse	
1.5.4 Ensure that police officers responding to incidents of domestic abuse have the confidence and skill to communicate with children and young people when needed, and information on how to make a referral.	ES175
Child trafficking	
1.5.5 When working with children and young people who have been trafficked, provide:	ES172, expert witness

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
• safe accommodation • legal support • specialist and trained interpreters where needed • culturally appropriate mental health services.	
1.6 Therapeutic interventions for children, young people and families after abuse and neglect	
1.6.1 Discuss in detail with children, young people and their families any interventions you offer them, explaining what the intervention will involve and how you think it may help.	GC consensus, children and young people's expert reference group
1.6.2 Give children, young people and their families a choice of proposed interventions where possible. Recognise that some interventions, although effective, may not suit that person or family.	GC consensus, children and young people's expert reference group
1.6.3 Take into account the age and developmental stage of the child or young person when selecting interventions.	GC consensus.
Therapeutic interventions following physical abuse, emotional abuse or neglect	
Children under 5 and their parents or carers	
1.6.4 Offer an attachment-based intervention to parents or carers who have neglected or physically abused a child under 5.	ES31, ES32, ES91, ES92.
1.6.5 Deliver the attachment-based intervention in the parent or carer's home and aim to: • improve how they nurture their child, including when the child is distressed • improve their understanding of what their child's behaviour means • help them respond positively to cues and expressions of the child's feelings • improve how they manage their feelings when caring for their child.	ES31, ES32, ES91, ES92, NICE guideline on children's attachment
1.6.6 Consider child–parent psychotherapy for parents or carers and children under 5 if the parent or carer has physically or emotionally abused or neglected the child, or the child has been exposed to domestic violence.	ES37, ES38, ES39

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
1.6.7 Ensure that child–parent psychotherapy: • is based on the Cicchetti and Toth model • consists of weekly sessions (lasting 45–60 minutes) over 1 year • is delivered in the parents' home, if possible, by a therapist trained in the intervention • involves directly observing the child and the parent–child interaction • explores the parents' understanding of the child's behaviour • explores the relationship between the emotional reactions of the parents and their perceptions of the child on the one hand, and the parents' own childhood experiences on the other hand. [This recommendation is adapted from NICE's guideline on children's attachment.]	ES37, ES38, ES39
Children under 12 and their parents or carers	
1.6.8 Consider a comprehensive parenting intervention for parents and children under 12 if the parent or carer has physically or emotionally abused or neglected the child. This should comprise weekly home visits for at least 6 months that address: • parent–child interactions • caregiving structures and parenting routines • parental stress • home safety • any other issues that caused the family to come to the attention of services. As part of the intervention, help the family to access other services they might find useful.	ES62, economic modelling
1.6.9 Consider parent–child interaction therapy for parents and children under 12 if the parent has physically abused or neglected the child. Combine group	ES40, ES41, ES42

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
sessions for these parents with individual child–parent sessions, focusing on developing child-centred interaction and effective discipline skills.	
Children and young people aged over 10 and their parents or carers	
1.6.10 Consider multi-systemic therapy for child abuse and neglect (MST-CAN) for parents, children and young people aged 10 to 17 if the parent has abused or neglected their child. This should: • involve the whole family • address multiple factors contributing to the problem • be delivered in the home or in another convenient location • include a round-the-clock on-call service to support families to manage crises.	ES56, ES57, ES58, ES59
Foster carers and those providing permanence for children under 5	
1.6.11 Offer an attachment-based intervention in the home to foster carers looking after children under 5 who have experienced abuse or neglect. Aim to help foster carers to: • improve how they nurture their foster child, including when the child is distressed • improve their understanding of what the child's behaviour means • respond positively to cues and expressions of the child's feelings • behave in ways that are not frightening to the child • improve how they manage their feelings when caring for their child. [This recommendation is adapted from the NICE guideline on children's attachment.]	ES33, ES34, ES35, ES36, NICE guideline on children's attachment
1.6.12 Consider the attachment-based intervention in recommendation 1.6.11 for adoptive parents and those providing permanence (including special guardians, foster carers or kinship carers) for children under 5 who have experienced abuse or neglect.	ES33, ES34, ES35, ES36

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
Foster carers and those providing permanence for children and young people aged 5 to 17	
1.6.13 For foster carers of children aged 5 to 12 who have experienced abuse and neglect, consider a group-based parent training intervention that includes strategies to manage behaviour and discipline positively. This should include using video, roleplay and homework practice.	ES55, economic modelling
1.6.14 For foster carers, adoptive parents and those providing permanence for children and young people aged 5 to 17 who have experienced abuse or neglect, consider a trauma-informed group parenting intervention, using a trust-based relational intervention as an example. It should help to: • develop the child's capacity for self-regulation • build trusting relationships • develop proactive and reactive strategies for managing behaviour.	ES194
Therapeutic interventions for children, young people and families after sexual abuse	
1.6.15 Consider group or individual trauma-focused cognitive behavioural therapy for children and young people (boys and girls) who have been sexually abused and show symptoms of anxiety, sexualised behaviour or post-traumatic stress disorder. When offering this therapy: • discuss it fully with the child or young person before providing it, in light of the fact that some children and young people do not find this intervention helpful • make clear that there are other options available if they would prefer • provide separate sessions for the non-abusing parent or carer.	ES64, ES65, ES66, ES67, ES68, ES69, EcES7, economic modelling, children and young people's expert reference group
1.6.16 For children and young people (boys and girls) aged 8 to 17 who have been sexually abused, consider a programme, for example ‘Letting the future in’, that:	ES188, ES189, EcES6

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
• emphasises the importance of the therapeutic relationship between the child and therapist • offers support tailored to the child's needs, drawing on a range of approaches including counselling, socio-educative and creative approaches (such as drama or art) • includes individual work with the child (up to 20 sessions, extending to 30 as needed) and parallel work with non-abusing parents or carers (up to 8 sessions).	
1.6.17 For girls aged 6 to 14 who have been sexually abused and who are showing symptoms of emotional or behavioural disturbance, consider one of the following after assessing carefully and discussing with the girl which option would suit her best: • individual focused psychoanalytic therapy (up to 30 sessions) or • group psychotherapeutic and psychoeducational sessions (up to 18 sessions). Provide separate sessions for the non-abusing parent or carer.	ES72, ES74
1.7 Planning and delivering services	
1.7.1 Plan services in a way that enables children, young people, parents and carers to work with the same professionals over time where possible.	ES140, ES152, children and young people's expert reference group
1.7.2 For cases involving children not already subject to protection plans, agencies responsible for planning and delivering statutory child protection services should agree common terminology to describe multi-agency working arrangements, including: • the terms used to describe meetings • defining who the lead practitioner is.	ES176
1.7.3 Agencies responsible for planning and delivering services for children should agree clear joint protocols for addressing abuse and neglect at the early help stage, and through statutory child protection processes. Ensure these:	ES178

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
• address less well-recognised forms of abuse, including child sexual exploitation, female genital mutilation, forced marriage and child trafficking, serious youth violence and gang membership • are communicated to all agencies, including those providing universal services.	
1.7.4 Agencies must address obstacles to partnership working, including agreeing ways to support sharing information when it is in a child or young person's best interests, in line with statutory guidance given in Working together to safeguard children. (For additional advice on this see the Department for Education's Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers.) For example, allow agreed database access to staff from other agencies, or integrate teams from different agencies.	ES26, ES168, ES169, ES179
1.7.5 Ensure staff from different agencies who are working on the same, or related, cases or issues are co-located wherever possible.	ES180
1.7.6 To address the risks posed by sexual exploitation and gangs, agencies responsible for planning and delivering services for children and young people should ensure there is: • effective leadership within agencies • a local lead who will coordinate planning and information sharing between agencies.	ES177
Supervision and support for staff	
1.7.7 For staff working in child protection from different agencies, particularly those who are co-located, provide ongoing opportunities to: • maintain their professional skills and competencies • stay in touch with colleagues from their own professional discipline.	GC consensus
1.7.8 Organisations should support staff working with children and families at risk of	ES182, GC consensus

Recommendation	Evidence statements and other supporting evidence (expert witness testimony guideline committee consensus)
or experiencing abuse, and ensure they have access to good quality supervision. This should include: • case management • reflective practice • emotional support • continuing professional development.	

3.11.2 Linking Evidence to Recommendations (LETR) tables

Topic/section heading	Safeguarding and communicating with children and young people
Recommendations	1.1.1 Take a child-centred approach to all work with children and young people; involve them in decision-making to the fullest extent possible depending on their age and developmental stage. 1.1.2 Use a range of methods (for example, using drawing, books or activities where appropriate) for communicating with children. Tailor communication to: • their age and developmental stage • any disabilities, for example learning difficulties or hearing and/or visual impairments • communication needs, for example by using communication aids or providing an interpreter (ensure the interpreter is not a family member). 1.1.3 In all conversations with children and young people: • explain confidentiality and when you might need to share specific information, and with whom • be sensitive and empathetic • listen actively and use open questions • find out their views and wishes • use plain language and explain any technical terms • work at the child or young person's pace • give them opportunities to stop the conversation or leave the room, and follow up if this does happen • explain what will happen next and when. 1.1.4 Make sure the child or young person is comfortable with the environment in which conversations are being held and ensure they have privacy if they want to discuss any worries. 1.1.5 If your interaction with a child or young person involves touching them (for example, a medical examination) explain what you are going to do. For young people over 16, or children and young people who are under 16 but are Gillick competent, ask for their agreement first. If they do not agree and touching them is essential to their treatment seek legal advice, unless the need for treatment is immediate. In all other cases respect their disagreement.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.
Review questions	8. What aspects of professional practice support and hinder effective assessment of risk and need in relation to child abuse and neglect? 20. What aspects of professional practice and ways of working support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect? With relevant material from:

	1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	The evidence for these recommendations was drawn from: • the review of what helps and hinders professional practice in relation to assessment. The evidence reviewed for this question comprised qualitative studies, including studies of the views and experiences of children, young people, adult survivors parents, carers and practitioners, which were of mixed quality. • the review of what helps and hinders professional practice in responding to abuse and neglect. The evidence reviewed for this question included mixed methods and qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. These studies were of mixed quality. Evidence on communication with young people (recommendation 1.1.3) was based on evidence relating to assessment, and drawn from 1 moderate quality UK serious case review synthesis, 1 moderate quality UK qualitative study and 1 poor quality UK thematic inspection study. Further evidence on experience of response was provided in 4 moderate quality UK qualitative study, and 1 poor quality UK qualitative study. There was 1 poor quality UK study on communicating with disabled children in the context of abuse and neglect (recommendation 1.1.2).
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations. They considered that these were primarily recommendations about the style of working with children and young people and would not require significant investment of resources. Committee members noted too that provision of interpreters is a standard practice within the sector.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES127 (recommendation 1.1.3) ES140 (recommendation 1.1.4) ES154 (recommendation 1.1.3) ES162 (recommendation 1.1.2)
Other considerations	Recommendation 1.1.1 is a guideline committee consensus recommendation, based on their practice experience and was a

	key overarching theme of committee discussions. The recommendation is also intended to provide context for the subsequent recommendations, emphasising that implementation of the recommendations may take a different form depending on the age of the child or young person. Recommendation 1.1.2 is based on evidence statement ES162 which referred to communication with disabled children. Although this was taken from evidence review relating specifically to what helps and hinders responding to abuse and neglect, the guideline committee thought that these findings applied to general principles of work with children and young people. Consensus discussions within the guideline committee expanded this point to include other types of communication needs. The issue of interpretation was also emphasised by the expert witness on forced marriage. Although ES127 and ES154, underpinning 1.1.3, were taken from evidence review relating specifically to assessment of, and responding to, abuse and neglect, the guideline committee thought that these findings applied to general principles of work with children and young people. The young people's expert reference group also made substantial input to this recommendation, based on their experience of using services. Recommendation 1.1.4 was based on ES140, which refers to being in a 'safe space' as a facilitator to help young people talk about abuse and neglect. The recommendation also drew on consensus discussions in the young people's expert reference group and the guideline committee. The young people in particular emphasised the importance of being in comfortable surroundings if you need to discuss difficult issues. Recommendation 1.1.5 was based on consensus discussions in the young people's expert reference group and guideline committee. The feedback from the young people on the draft recommendations highlighted that some young people do not want to be touched. This was supported by the guideline committee. However, it was acknowledged that for practitioners who need to touch children and young people, for example doctors, this should be explained to and agreed with the young person first taking in to account their ability to give consent (Gillick competence).

Topic/section heading	Working with children and young people
Recommendations	1.1.6 Produce a written record of conversations with children and young people and check that they agree with these (this could include both of you signing the record). Ensure their words are accurately represented, using their actual words if possible. 1.1.7 Share reports and plans with the child or young person in a way that is appropriate to their age and understanding. 1.1.8 When working with children and young people, always do what you say you are going to do. If circumstances change and

	this is no longer possible, explain why as soon as possible, and offer alternative actions. 1.1.9 When working with children and young people, clearly explain how you will work together with them and ensure they do not have unrealistic expectations. 1.1.10 Explain to the child or young person (if age appropriate) how and when they can contact you and what services are available out of hours. Give them contact details. 1.1.11 Agree with the child or young person how and when you will contact them, bearing in mind safety issues such as whether a perpetrator of abuse may have access to a young person's phone. Agree what will happen if you contact them and they do not respond, for example following up with their nominated emergency contact.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.
Review questions	14. What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect? 20. What aspects of professional practice and ways of working support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect? With relevant material from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	The evidence for these recommendations was drawn from: • the review of what helps and hinders professional practice in relation to early help. The evidence reviewed for this question comprised largely qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. The quality of evidence for the overall question was mixed. • the review of what helps and hinders professional practice in responding to abuse and neglect. The evidence reviewed for this question included mixed methods and qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. These studies were of mixed quality. Evidence relating to children, young, people and adult survivors' views on using services (recommendations 1.1.7, 1.1.8 and

	1.1.11) was based on 2 moderate quality UK qualitative studies, 1 moderate quality Irish study, 1 poor quality UK qualitative study and 1 poor quality UK mixed methods study.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendationsThe Committee considered these recommendations to relate primarily to the style of working with children and young people and, therefore, that they would not require significant investment of resources.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES153 (recommendation 1.1.7, 1.1.8, 1.1.9, 1.1.11)
Other considerations	Recommendation 1.1.6 was based on the views of the children and young people's expert reference group. The young people talked about the importance of being able to see written records and reports that are about them. They also suggested that it might be helpful for young people and professionals to 'co-sign' reports to show that they both agree with the content. The guideline committee also acknowledged the importance of young people being able to see that they have been listened to. Recommendation 1.1.7 was based on ES153 and also on the views of the children and young people's expert reference group. The young people said that they would like to see documents about them, but also gave examples of occasions when they had found out information through reading reports which they had not previously known, or were not ready to hear. Recommendations 1.1.8 was based on the views of the children and young people's expert reference group, and was supported by the views of the guideline committee who thought that trust could be undermined when practitioners did not honour commitments, even for very good reason. Recommendations 1.1.9 to 1.1.11 were based on ES153 and also on the views of the children and young people's expert reference group. Some recommendations were based on negative experiences that the young people had had of services in the past, and of what would have made these better. The views of the young people were also supported by the experience of the guideline committee.

Topic/section heading	Working with parents and carers
Recommendations	1.1.12 Aim to build good working relationships with parents and carers to encourage their engagement and continued participation. This should involve:

	• actively listening to them • being open and honest • avoiding blame, even if parents may be responsible for the abuse or neglect • inviting, recognising and discussing any worries they have about specific interventions they will be offered • identifying what parents are currently doing well, and building on this • working in a way that enables trust to develop while maintaining professional boundaries • being reliable, and available as promised • keeping them informed, including explaining what information has been shared, and with whom • being clear about the issues and concerns that have led to your involvement • being clear about the legal context in which your involvement with them is taking place. 1.1.13 Coordinate your work with practitioners in other agencies so that children, young people, parents and carers do not need to give the same information repeatedly. 1.1.14 Think critically and analytically about cases and do not rely solely on protocols, proformas and electronic recording systems to support your professional thinking and planning.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.
Review questions	8. What aspects of professional practice support and hinder effective assessment of risk and need in relation to child abuse and neglect? 14. What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect? 20. What aspects of professional practice and ways of working support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect? 21. What organisational factors support and hinder effective multi-agency working including supporting good professional judgement? With relevant information from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

Quality of evidence	These recommendations draw on evidence from the reviews on: • what helps and hinders professional practice in relation to assessment. The evidence reviewed for this question comprised qualitative studies, including studies of the views and experiences of children, young people, adult survivors parents, carers and practitioners, which were of mixed quality. • what helps and hinders professional practice in relation to early help. The evidence reviewed for this question comprised largely qualitative studies, including studies of the views and experiences of children, young people, adult survivors parents, carers and practitioners. The quality of evidence for the overall question was mixed. • what helps and hinders professional practice in responding to abuse and neglect. The evidence reviewed for this question included mixed methods and qualitative studies, including studies of the views and experiences of children, young people, adult survivors parents, carers and practitioners. These studies were of mixed quality. • organisational factors to support multi-agency practice. The evidence reviewed for this question comprised largely qualitative studies and syntheses of serious case review data. These were mostly of good or moderate quality. Evidence on building good relationships with carers was provided in 2 moderate quality correlational studies, 1 German and 1 from the USA; 3 moderate quality UK serious case review syntheses; 1 poor quality UK mixed methods study; 1 good quality UK qualitative study; 10 moderate quality qualitative studies (7 UK, 2 US, 1 Irish) and 8 poor quality qualitative studies (6 UK and 1 Australian). Use of electronic recording systems and their influence on professional judgement was explored in 2 good quality UK qualitative studies and 2 moderate quality serious case review syntheses.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations The Committee considered these recommendations to relate primarily to the style of working with children and young people and, therefore, that they would not require significant investment of resources.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES19 (recommendation 1.1.12) ES20 (recommendation 1.1.12) ES128 (recommendation 1.1.12) ES132 (recommendation 1.1.12) ES153 (recommendation 1.1.13) ES158 (recommendation 1.1.12, 1.1.13) ES160 (recommendation 1.1.12) ES161 (recommendation 1.1.12)

	ES179 (recommendation 1.1.14)
Other considerations	Recommendation 1.1.12 was based on ES19, 20, 128, 132, 158, 160 and 161. This evidence came from the reviews on assessment, early help and response, but the guideline committee thought that the principles of effective relationships applied to all work with families. The reference to 'non-blaming' was derived from ES20 which makes reference to the fact that service users value a non-judgemental approach. However, the committee decided to amend the language in light of the fact that professional judgement does need to be exercised - but families should not be made to feel 'judged' for their situation. The committee thought that the concept of 'blame' conveyed this more accurately. The guideline committee also added from their own experience points regarding being available as promised, and being clear about the legal context for the work. Recommendation 1.1.13 was based on ES153 and 158 and on the experience of the children and young people's expert reference group. This was considered by the children and young people's expert reference group to be an important recommendation. Recommendation 1.1.14 was based on ES179, and in particular evidence relating to 2 syntheses of serious case review data. The guideline committee also talked about the importance of critical and analytical thinking, but that this is not always supported or encouraged by the format of paper and electronic recording systems professionals are given to use.

Topic/section heading	Children and young people telling others about abuse and neglect
Recommendations	1.2.1 Recognise that children and young people who are being abused or neglected may find it difficult to tell someone for the first time because: • they may have feelings of shame, guilt and of being stigmatised • they may not always recognise their own experiences as abusive • they may be being coerced by (or may be attached to) their abuser • they may fear the consequences of telling someone, for example that the abuse might get worse, their family will be split up or they will go into care. 1.2.2 Recognise that children and young people who are experiencing abuse or neglect may not acknowledge this when questioned, or may not want others to know. 1.2.3 Recognise that children and young people may communicate their abuse or neglect indirectly through their behaviour and appearance (see NICE's guideline on child maltreatment and recommendations 1.2.12 to 1.2.45 in this guideline).

	1.2.4 Explore your concerns with children and young people in a non-leading way, for example by using open questions, if you are worried that they may be being abused or neglected. 1.2.5 Avoid causing possible prejudice to any formal investigation during early conversations about abuse and neglect with children and young people. Follow guidance in the Ministry of Justice's Achieving best evidence in criminal proceedings. 1.2.6 If a child or young person tells you that they have experienced abuse or neglect, explain to them whom you will need to tell, and discuss what will happen next and when. Avoid setting unrealistic expectations.
Research recommendations	What approaches to practice enable children (both boys and girls) who have been sexually abused to begin to tell practitioners about their experiences earlier, and in a way that does not contaminate the reliability of subsequent court proceedings? What are the weaknesses in the statutory reporting system for child abuse and neglect?
Review questions	6. What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action? With relevant information from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	The evidence for these recommendations was taken from the review of what helps and hinders professional practice in relation to recognition. The evidence comprised qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. These were of mixed quality. The evidence on children, young people and adult survivors' experiences of recognising their own abuse was provided in 3 good quality UK qualitative studies and 2 poor quality UK qualitative studies. The evidence on experiences of disclosing abuse was provided in comprising 4 good quality UK qualitative studies, 1 moderate quality UK study and 2 poor quality UK qualitative studies. Evidence on children, young people and adult survivors' experiences of communicating abuse via their behaviour was provided in 3 good quality UK qualitative studies and 2 poor quality UK qualitative studies. Evidence on informal and informal disclosures of abuse was provided in 3 good quality UK

	qualitative studies, 1 good quality UK qualitative study and 1 poor quality UK qualitative study. Evidence on disclosing abuse in Asian communities was provided in 1 poor quality UK qualitative study. Evidence on disclosing exposure to domestic abuse was provided in 1 moderate quality UK study. Evidence on emphasis on disclosure was provided in 1 good quality UK qualitative study.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations. The Committee considered these recommendations to relate primarily to the style of working with children and young people and, therefore, that they would not require significant investment of resources.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES139 (recommendations 1.2.1, 1.2.2, 1.2.3) ES140 (recommendations 1.2.1, 1.2.2, 1.2.3) ES141 (recommendations 1.2.1, 1.2.2, 1.2.3, 1.2.6) ES142 (recommendations 1.2.6) ES144 (recommendations 1.2.1, 1.2.2) ES145 (recommendations 1.2.1, 1.2.2) ES147 (recommendations 1.2.4, 1.2.5)
Other considerations	Recommendations 1.2.1 and 1.2.2 were based on ES139-141 and ES144-145. This was supported by the experience of the children and young people's expert reference group members, and of Guideline Committee members. This was supported by the experience of the children and young people's expert reference group members, and of guideline committee members. In addition to what was in the evidence statements, the children and young people's reference group added reference to being coerced by, or attached to, their abuser and fears of splitting their family up. The expert reference group thought it was important to remind practitioners that children and young people may conceal abuse and neglect (recommendation 1.3.2). Recommendation 1.2.3 was based on ES139-141. This was also supported by the experiences of the children and young people's expert reference group members, who gave numerous examples of changes in their emotions or behaviour which could have alerted professionals that something was wrong. The guideline committee also noted examples from their own experience of behaviours and demeanour that signalled abuse and neglect. Recommendations 1.2.4 and 1.2.5 were based on ES147, which emphasised that the onus should be on professionals to follow up concerns they may have about young people. The children and young people's expert reference group provided clear information about the kinds of conversations and approaches that would enable them to talk about abuse and neglect, and emphasised the importance of starting with broad and open questions to allow the young person to talk if they want to. The guideline committee also took in to consideration guidelines to ensure that

	conversations about abuse and neglect do not contaminate evidence that is later used in court. Recommendation 1.2.6 was based on ES141 and 142 and was supported by the guideline committee's professional experience, and the experience of the children and young people's expert reference group who said that that there was a need for professionals to give children and young people more information about what will happen next after they have told someone that they are being abused or neglected, and the timescales for action.

Topic/section heading	Risk factors for abuse and neglect
Recommendations	1.2.7 For disabled children, be aware that their disability may increase the risk of abuse or neglect by their parents, carers or others, and make it harder to recognise. Also remember that disabled children may have many carers. 1.2.8 Recognise that both girls and boys can be sexually exploited, and that child sexual exploitation is not confined to a particular sexual orientation. 1.2.9 Consider whether a child or young person may be being abused or neglected if a parent, carer, sibling or other adult in a child's household has 1 or more of the following risk factors: • They have substance misuse difficulties. • There is a history of domestic abuse. • They are emotionally volatile or have problems managing their anger. • They are experiencing mental health problems. The risk factors above may be compounded if the parent, carer, sibling or other adult in a child's household lacks support from family or friends. 1.2.10 Recognise the following as risk factors for recurring or persistent child abuse and neglect: • the parent or carer does not engage with services • there have been 1 or more previous episodes of abuse or neglect • the parent or carer has a mental health or substance misuse problem • there is chronic parental stress • the parent or carer experienced abuse or neglect as a child. Recognise that neglect and emotional abuse are more likely to recur or persist than other forms of abuse. 1.2.11 Ensure that practitioners understand that risk factors can be interrelated, and that separate factors can combine to increase the risk of harm to a child.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.

Review questions	3. What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect? 4. What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect? 6. What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action? 14. What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect? With relevant information from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	The evidence for these recommendations was taken from: • the review of risk factors and indicators associated with abuse or neglect. The evidence reviewed comprised systematic review of cross-sectional, longitudinal and case control studies, and cross-sectional studies relating to language development. The majority of studies were rated as moderate quality • the review of what helps and hinders professional practice in relation to recognition. The evidence comprised qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. These were of mixed quality. • the review of what helps and hinders professional practice in relation to early help. The evidence reviewed for this question comprised largely qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. The quality of evidence for the overall question was mixed. Evidence on the association between child disability and maltreatment was provided in good quality systematic review of 4 population-based studies and 1 was a moderate quality meta-analysis of 11 cross-sectional and cohort studies. One study was a poor quality meta-analysis of 155 studies exploring a range of risk factors for child abuse and neglect, including child disability. Evidence on child sexual exploitation was provided by 1 moderate-quality UK qualitative study.

	Evidence on parental risk factors for occurrence of abuse was provided in 1 poor quality meta-analysis of 155 studies and 1 good quality systematic review of 16 studies. The latter review also provided evidence on recurrence of abuse.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES27 (recommendation 1.2.11) ES95 (recommendation 1.2.7) ES106 (recommendation 1.2.9) ES107 (recommendation 1.2.10) ES108 (recommendation 1.2.9) ES112 (recommendation 1.2.9) ES113 (recommendation 1.2.10) ES115 (recommendation 1.2.9) ES116 (recommendation 1.2.10) ES117 (recommendation 1.2.9) ES118 (recommendation 1.2.10) ES120 (recommendation 1.2.10) ES121 (recommendation 1.2.9) ES122 (recommendation 1.2.10) ES123 (recommendation 1.2.10) ES149 (recommendation 1.2.8)
Other considerations	Recommendation 1.2.7 was based on ES95, which was taken from a moderate quality meta-analysis and a good quality systematic review and showed that overall disabled children are more likely to experience all forms of abuse and neglect. Although the evidence suggested that some forms of disability are not associated with higher risk of abuse and neglect, for example sensory disorders and autism, the guideline committee thought that the overall weight of evidence suggested that this was a risk factor to be aware of. The guideline committee were aware of the possibility of stigmatising the parents of disabled children, however it was noted that in this recommendation, disability is being presented solely as a risk factor (rather than a deterministic predictor of abuse or neglect), which would need to be considered carefully alongside other risk factors and any indicators. The guideline committee's experience also suggested that when a child is disabled, this can make it more difficult for professionals to recognise that they are being abused or neglected, as the symptoms may be 'masked', or apparently explained, by their impairments. The guideline committee also noted that the network of adults and professionals to take in to consideration in instances of suspected or actual abuse is often larger for disabled children. Recommendation 1.2.8 was based on ES149, which suggested that practitioners may be less aware of child sexual exploitation among boys and young men, and may be less aware of how sexual exploitation can manifest for young gay men. This was supported by the professional experience of the guideline

	committee, and also by the testimony of the expert witness on child sexual exploitation. Recommendation 1.2.9 was based on ES106, 108, 112, 115, 117, 121. The guideline committee were very aware of the possibility of stigmatising individuals who have the characteristics mentioned. However, the committee's view was that these should be considered as risk factors alongside other sources of information, rather than deterministic predictors of abuse or neglect. The meta-analysis on which many of the evidence statements were based was judged to be of poor quality, largely due to the high level of heterogeneity in the data contributing to estimates of effect size. The guideline committee therefore considered the findings of the meta-analysis alongside their own experience. The committee thought that mental health problems, substance misuse and domestic abuse were a well-known 'toxic trio' known to be associated with abuse and neglect. The evidence on emotional volatility and anger was also of poor quality, but again was recognised from the practice experience of the committee. The committee have noted lack of support from family or friends as a potential compounding factor, rather than as a risk factor in its own right. Recommendation 1.2.10 was based on ES107, 113, 116, 118, 120, 122, 123. As for previous recommendations, the guideline committee did not intend these recommendations to 'label' individuals with these characteristics, and were particularly concerned about stigmatising parents who themselves have experienced abuse. It was the intention of the committee that these should be considered as risk factors alongside other sources of information, rather than deterministic predictors of abuse or neglect. Several of the evidence statements were based on the same poor quality meta-analysis and so were considered in the context of the guideline committee's experience. The evidence suggested that neglect was the most likely form of abuse to persist or recur. However the guideline committee suggested from their own experience that emotional abuse was also likely to be persistent/recurrent. Recommendation 1.2.11 was based on ES27. This related to evidence from the question on early help. However, the guideline committee thought that this issue was more broadly relevant within the context of recognition. The guideline committee also considered evidence on the following potential risk factors: age of child (ES96, 97), gender of child (ES98, 99) and parental ill health (ES111). These did not show a significant association. The guideline committee thought that parent–child interaction (ES103) and corporal punishment (ES104) were already sufficiently covered by the adopted recommendations from CG89. The evidence on risk due to child internalising and externalising problems (ES100), child social competency (ES101) and prenatal problems (ES102) was considered insufficiently strong to make a recommendation. Evidence on risk due to parent age (ES105), single parenthood (ES109), parental unemployment (ES110), criminal behaviour

	(ES114) and parenting skills (ES119) was also considered to be insufficiently strong to make a recommendation.

Topic/section heading	Children and young people's behaviour and emotional states – general
Recommendations	1.2.12 Consider current abuse and neglect if a child or young person displays, or is reported to display, either of the following that differs from what would be expected for their age and developmental stage (see boxes 1 and 2): a marked change in behaviour or emotional state or repeated, extreme or sustained emotional responses. Consider abuse and neglect even if these initially appear to be explained by a known stressful situation (for example, bereavement or parental separation).* Box 1. Examples of behaviour and emotional states • Being fearful or withdrawn, low self-esteem • Extreme distress • Wetting and soiling • Recurrent nightmares containing similar themes • Aggressive, oppositional behaviour • Withdrawal of communication • Lack of ability to understand and recognise emotions • Habitual body rocking • Indiscriminate contact or affection seeking • Over-friendliness to strangers, including healthcare practitioners • Excessive clinginess • Persistently seeking attention • Demonstrating excessively 'good' behaviour to prevent parental or carer disapproval • Failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed • Coercive controlling behaviour towards parents or carers • Very young children showing excessive comforting behaviours when witnessing parental or carer distress. Box 2. Examples of emotional responses • Frequent rages at minor provocation • Distress expressed as inconsolable crying • Anger or frustration expressed as a temper tantrum in a school-aged child. 1.2.13 Consider past (as well as current) abuse and neglect if a child or young person shows repeated, extreme or sustained emotional responses as described in 1.2.12. 1.2.14 Consider current or past abuse and neglect if a child shows dissociation (transient episodes of detachment that are

	outside the child's control and that are distinguished from daydreaming, seizures or deliberate avoidance of interaction).* 1.2.15 Consider current or past abuse or neglect if children or young people are showing any of the following behaviours: • substance or alcohol misuse • self-harm • eating disorders • suicidal behaviours • bullying or being bullied. 1.2.16 Consider current or past abuse and neglect if a child or young person has run away from home or care.* 1.2.17 Consider current or past abuse and neglect if a child or young person is living in alternative accommodation without the justified agreement of their parents or carers.* 1.2.18 Consider abuse and neglect if a child or young person regularly has responsibilities that interfere with the child's essential normal daily activities (for example, school attendance).* 1.2.19 Consider current or past abuse and neglect if a child responds to a health examination or assessment in an unusual, unexpected or developmentally inappropriate way (for example, extreme passivity, resistance or refusal).*
Research recommendations	When should under- or over-eating be a cause for concern about abuse and neglect?
Review questions	3. What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect? 4. What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect? Review of NICE guidance on child maltreatment.
Quality of evidence	Recommendations 1.2.12, 1.2.13, 1.2.14, 1.2.16, 1.2.17, 1.2.18 and 1.2.19 were adopted from the NICE guideline on child maltreatment. Evidence for adding emotion recognition to the list of indicators in 1.2.12 was provided by 1 moderate quality systematic review of 19 studies and 1 poor quality systematic review citing 1 case control study and 1 prospective study. The evidence for recommendation 1.2.15 was taken from the review of risk factors and indicators associated with abuse or neglect. The evidence reviewed comprised systematic review of cross-sectional, longitudinal and case control studies, and cross-sectional studies relating to language development. The majority of studies were rated as moderate quality. Evidence on indicators of abuse was provided by 1 poor quality systematic review of 31 studies in relation to substance misuse, 4 moderate quality systematic reviews (total of 80 studies) in relation to suicidal behaviour and self-harm and 1 moderate quality systematic review of 6 studies on the association between bullying and being a 'bully/victim' and abuse or neglect.

Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES78 (recommendation 1.2.12) ES86 (recommendation 1.2.15) ES87 (recommendation 1.2.15) ES88 (recommendation 1.2.15) ES89 (recommendation 1.2.15) ES90 (recommendation 1.2.15)
Other considerations	Recommendations 1.2.12, 1.2.13, 1.2.14, 1.2.16, 1.2.17, 1.2.18 and 1.2.19 were adopted from the NICE guideline on child maltreatment. The children and young people's Expert Reference Group also identified a number of indicators which could have helped professionals to identify that they were being abused or neglected. These included being withdrawn, problems with sleep, being scared or distressed, self-harm, being aggressive and problems with eating. The guideline committee cross-referenced these to ensure they were covered by the recommendations. Our Guideline Committee requested a number of amendments to these recommendations based on consensus discussions. In particular, the group wanted to reflect that some behaviours and emotional states may be indicative of past abuse and neglect (for example, which occurred prior to a child being fostered or adopted). This is reflected in the wording of recommendations 1.2.13, 1.2.14, 1.2.15, 1.2.16, 1.2.17 and 1.2.19. These were agreed with NICE. Recommendations 1.2.12 and 1.2.13 were adopted from the NICE guideline on child maltreatment. Based on ES78, the guideline committee added reference to difficulty in emotion recognition as an indicator of abuse or neglect. The guideline committee also requested an amendment to the wording of the recommendation to make it clear that unusual behaviours should be investigated even if they appear to be explained by current stressful or traumatic situations other than abuse or neglect. This was on the basis of the professional experience of the guideline committee. Recommendation 1.2.14 was adopted from the NICE guideline on child maltreatment. Recommendation 1.2.15 was based on ES86, 87, 88, 90 which showed significant associations between abuse and neglect and suicide and self-harm, substance misuse, bullying and being bullied. Reference to eating disorders was added as a consensus recommendation from the guideline committee's professional experience. These indicators were also mentioned by the children and young people's expert reference group. Recommendations 1.2.16 and 1.2.17 were based on a single recommendation in the NICE guideline on child maltreatment. The committee thought that this recommendation needed to be split to make it clearer. They have added in the phrase 'justified agreement' because parents with poor judgement about the

	child's safety may give their 'full agreement' but this may not indicate that they child is safe. Recommendations 1.2.18 and 1.2.19 were adopted from the NICE guideline on child maltreatment with no amendments. The guideline committee also considered evidence on internalising and externalising behaviour and trauma symptoms as indicators of abuse or neglect (ES75, 76 and 77) but thought that these were covered by the recommendations adopted from child maltreatment. The evidence on attachment style (ES79) and peer relationships as an indicator (ES81) was considered to be insufficiently strong to make a recommendation.

Topic/section heading	Children and young people's behaviour and emotional states – sexual behaviour and poor care
Recommendations	1.2.20 Suspect current or past abuse and neglect if a child or young person's sexual behaviour is indiscriminate, precocious or coercive.* 1.2.21 Suspect abuse and neglect, and in particular sexual abuse, if a pre-pubertal child displays or is reported to display repeated or coercive sexualised behaviours or preoccupation (for example, sexual talk associated with knowledge, emulating sexual activity with another child).* 1.2.22 Suspect sexual abuse if a pre-pubertal child displays or is reported to display unusual sexualised behaviours. Examples include: • oral–genital contact with another child or a doll • requesting to be touched in the genital area • inserting or attempting to insert an object, finger or penis into another child's vagina or anus.* 1.2.23 Refer to the NICE guideline on harmful sexual behaviour among children and young people for further guidance about responding to potentially harmful sexual behaviours. 1.2.24 Suspect current or past abuse and neglect if a child repeatedly scavenges, steals, hoards or hides food with no medical explanation (for example Prader–Willi syndrome).* 1.2.25 Suspect neglect if you repeatedly observe or hear reports of any of the following in the home that is in the parents or carers' control: • a poor standard of hygiene that affects a child's health • inadequate provision of food • a living environment that is unsafe for the child's developmental stage. Be aware that it may be difficult to distinguish between neglect and material poverty. However, care should be taken to balance recognition of the constraints on the parents or carers' ability to meet their children's needs for food, clothing and shelter with an appreciation of how people in similar circumstances have been able to meet those needs.* 1.2.26 Suspect neglect if a child is persistently smelly and dirty. Take into account that children often become dirty and smelly

	during the course of the day. Use judgement to determine if persistent lack of provision or care is a possibility. Examples include: • child seen at times of the day when it is unlikely that they would have had an opportunity to become dirty or smelly (for example, an early morning visit) • if the dirtiness is ingrained.* 1.2.27 Consider neglect if a child has severe and persistent infestations, such as scabies or head lice.* 1.2.28 Consider neglect if a child's clothing or footwear is consistently inappropriate (for example, for the weather or the child's size). Take into account that instances of inadequate clothing that have a suitable explanation (for example, a sudden change in the weather, slippers worn because they were closest to hand when leaving the house in a rush) would not be alerting features for possible neglect.*
Research recommendations	When should under- or over-eating be a cause for concern about abuse and neglect?
Review questions	3. What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect? 4. What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect? Review of NICE guidance on child maltreatment.
Quality of evidence	These recommendations were adopted from the NICE guideline on child maltreatment. Our Guideline Committee requested a number of amendments to these recommendations based on consensus discussions. In particular, the group suggested that reference to children's drawings be removed from recommendation 1.2.21. The evidence on children's drawings was taken from the review of risk factors and indicators associated with abuse or neglect. The evidence on drawings was taken from 1 poor quality systematic review of 23 controlled comparative studies.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES94 (recommendation 1.2.21)
Other considerations	Recommendation 1.2.20 was adopted from the NICE guideline on child maltreatment with no amendments. Recommendation 1.2.21 was adopted from the NICE guideline on child maltreatment. It was agreed with NICE that reference to

	children's drawings would be removed from recommendation 1.2.21. This was based on evidence presented in ES94 which suggested there is no reliable association between the content of children's drawings and experiencing abuse or neglect. The guideline committee discussed the fact that this does not mean that drawing cannot be used as a communication or assessment tool, but rather that children's spontaneous drawings should not be regarded as a reliable indicator of abuse or neglect. Recommendation 1.2.22 was adopted from the NICE guideline on child maltreatment with no amendments. Recommendation 1.2.23 was based on consideration of the NICE guideline on harmful sexual behaviour among children and young people. Although this guideline does not include practice in relation to children and young people who have been sexually abused, it does contain recommendations relating to responding to potentially sexual harmful behaviours. Recommendation 1.2.24 was adopted from the NICE guideline on child maltreatment. Reference to Prader-Willi syndrome was added by the guideline committee based on their professional experience as an example of a possible medical explanation for the behaviour described. Recommendation 1.2.25 was adopted from the NICE guideline on child maltreatment with minor wording changes suggested by the NICE editors. Recommendation 1.2.26 was adopted from the NICE guideline on child maltreatment with minor wording changes suggested by the NICE editors. Recommendation 1.2.27 was adopted from the NICE guideline on child maltreatment with no amendments. Recommendation 1.2.28 was adopted from the NICE guideline on child maltreatment with minor wording changes suggested by the NICE editors.

Topic/section heading	Children and young people's development
Recommendations	1.2.29 Consider neglect if a child displays faltering growth because of lack of provision of an adequate or appropriate diet.* 1.2.30 Consider physical or emotional abuse or neglect if a child under 12 shows poorer than expected language abilities for their overall development (particularly in their ability to express their thoughts, wants and needs), which is not explained by other factors, for example speaking English as a second language.
Research recommendations	When should under- or over-eating be a cause for concern about abuse and neglect?
Review questions	3. What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect? 4. What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect?

	Review of NICE guidance on child maltreatment.
Quality of evidence	The evidence for recommendation 1.2.28 was taken from the reviews supporting NICE guidance on child maltreatment. The evidence for recommendation 1.2.29 was taken from the review of risk factors and indicators associated with abuse or neglect. Evidence on language development was drawn from 1 moderate quality US prospective cohort study, and 8 observational comparative studies, broadly comparing abused with non-abused children at a single time point. Of these, 5 were moderate quality US studies, 1 was a moderate quality UK study, 1 was a poor quality US study and 1 was a poor quality Canadian study.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES80 (recommendation 1.2.30) ES93 (recommendation 1.2.30)
Other considerations	Recommendation 1.2.29 was adopted from the NICE guideline on child maltreatment. The guideline committee had substantial discussion regarding whether reference should be made to obesity within this recommendation. In the experience of many Guideline Committee members, obesity and over-eating can be associated with abuse and neglect. However, other Committee members were concerned that obesity is prevalent in the general population, and so could lead to over-identification. It was agreed that more evidence is needed and therefore a research recommendation was made. Recommendation 1.2.30 was based on ES80 and ES93. In ES93, the included studies had found a relationships between language delay and general maltreatment, physical abuse and neglect. One moderate quality study had examined the relationship between sexual abuse and language development, and found that there was no relationship until late teenage years (15 to 18). However, the committee thought that differences in language development in this age group would be more difficult to observe. The committee therefore made this recommendation specific to younger children, and so also specified a link to physical abuse, neglect and emotional abuse (but not sexual abuse). The guideline committee thought it was particularly important to highlight expressive language, as the included studies found this to be more strongly associated with abuse and neglect.

Topic/section heading	Parent–child interactions - general

Recommendations	1.2.31 Consider neglect or physical abuse if a child's behaviour towards their parent or carer shows any of the following, particularly if they are not observed in the child's other interactions: • dislike or lack of cooperation • lack of interest or low responsiveness • high levels of anger or annoyance • seeming passive or withdrawn. 1.2.32 Consider emotional abuse if there is concern that parent–or carer–child interactions may be harmful. Examples include: • Negativity or hostility towards a child or young person. • Rejection or scapegoating of a child or young person. • Developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining. • Exposure to frightening or traumatic experiences, including domestic abuse. • Using the child for the fulfilment of the adult's needs (for example, in marital disputes). • Failure to promote the child's appropriate socialisation (for example, involving children in unlawful activities, isolation, not providing stimulation or education).* 1.2.33 Suspect emotional abuse if the interactions observed in recommendation 1.3.32 are persistent.* 1.2.34 Consider emotional neglect if there is emotional unavailability and unresponsiveness from the parent or carer towards a child or young person and in particular towards an infant.* 1.2.35 Suspect emotional neglect if the interaction observed in recommendation 1.3.34 is persistent.* 1.2.36 Consider abuse and neglect if parents or carers are seen or reported to punish a child for wetting and soiling despite practitioner advice that the symptom is involuntary.* 1.2.37 Consider abuse and neglect if a parent or carer refuses to allow a child or young person to speak to a practitioner on their own when it is necessary for the assessment of the child or young person.* 1.2.38 Recognise that excessive physical punishment constitutes physical abuse.
Research recommendations	When should under- or over-eating be a cause for concern about abuse and neglect?
Review questions	3. What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect? 4. What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect? Review of NICE guidance on child maltreatment.

Quality of evidence	The evidence for recommendations 1.2.31 and 1.2.38 was taken from the review of risk factors and indicators associated with abuse or neglect. Evidence on child behaviour was provided by 1 moderate quality systematic review that reviewed 30 studies to assess how physically abused and neglected children are distinguished from non-maltreated children during interactions with their parents, and 1 poor quality systematic review of 35 studies of a range of emotional, behavioural and developmental indicators. Evidence on physical punishment was taken from 1 poor-quality meta-analysis of 155 studies covering a range of indicators of abuse/neglect, of which 7 related to physical punishment. The evidence for recommendations 1.2.32 to 1.2.37 was taken from the reviews supporting NICE guidance on child maltreatment.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES82 (recommendation 1.2.31) ES83 (recommendation 1.2.31) ES84 (recommendation 1.2.31) ES85 (recommendation 1.2.31) ES104 (recommendation 1.2.38)
Other considerations	Recommendation 1.2.31 was based on ES82 to 85. The evidence relating to passivity was based on a poor quality systematic review, but was supported by the guideline committee's experience. The guideline committee discussed whether this recommendation should be qualified by whether these behaviours may be explained by other factors, but the view of the committee was that abuse or neglect should be considered in these instances, even if there was seemingly an explanation. However, the committee did add reference to the specificity of negative behaviours (that is, that they are not observed in interactions with others). As with other recommendations in these sections, the group thought that these indicators would need to be considered alongside other evidence and indicators. Recommendations 1.2.32 and 1.2.33 were adopted from the NICE guideline on child maltreatment but with a wording to change to make it clearer that you should consider maltreatment if you observe something once, but suspect maltreatment if it persists. Recommendations 1.2.34 and 1.2.35 were adopted from the NICE guideline on child maltreatment but with a wording to change to make it clearer that you should consider maltreatment if you observe something once, but suspect maltreatment if it persists.

	Recommendation 1.2.36 was adopted from the NICE guideline on child maltreatment. The guideline committee added reference to soiling based on their professional experience. Recommendation 1.2.37 was adopted from the NICE guideline on child maltreatment with a minor wording change of 'healthcare professional' to 'practitioner' to make this recommendation more widely applicable. Recommendation 1.2.38 was based on ES104. Although this suggested an association between 'excessive physical punishment' and physical abuse, the GC noted that excessive physical punishment is constitutive of physical abuse.

Topic/section heading	Supervision by parents and carers
Recommendations	1.2.39 Suspect neglect if parents or carers persistently fail to anticipate dangers and to take precautions to protect their child from harm. However, take into account that achieving a balance between an awareness of risk and allowing children freedom to learn by experience can be difficult.* 1.2.40 Consider neglect if the explanation for an injury (for example, a burn, sunburn or an ingestion of a harmful substance) suggests a lack of appropriate supervision.* 1.2.41 Consider neglect if a child or young person is not being cared for by a person who is able to provide adequate care.* 1.2.42 Consider neglect if parents or carers fail to collect or administer essential prescribed treatment for their child.* 1.2.43 Consider neglect if parents or carers repeatedly fail to attend follow-up appointments that are essential for their child's health and wellbeing.* 1.2.44 Consider neglect if parents or carers persistently fail to engage with relevant child health promotion programmes which include: • immunisation • health and development reviews • screening.* 1.2.45 Consider neglect if parents or carers have access to but persistently fail to obtain NHS treatment for their child's dental caries (tooth decay).* 1.2.46 Suspect neglect if parents or carers fail to seek medical advice for their child to the extent that the child's health and wellbeing is compromised, including if the child is in ongoing pain.*
Research recommendations	When should under- or over-eating be a cause for concern about abuse and neglect?
Review questions	Review of NICE guidance on child maltreatment.
Quality of evidence	The evidence for recommendations 1.2.39 to 1.2.46 was taken from the reviews supporting NICE guidance on child maltreatment.

Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations.
Evidence statements – numbered evidence statements from which the recommendations were developed	The evidence for recommendations 1.2.39 to 1.2.46 was taken from the reviews undertaken when developing the NICE guideline on child maltreatment.
Other considerations	Recommendation 1.2.39 was adopted from the NICE guideline on child maltreatment with minor wording changes suggested by NICE editors. Recommendation 1.2.40 was adopted from the NICE guideline on child maltreatment with no amendments. Recommendation 1.2.41 was adopted from the NICE guideline on child maltreatment with no amendments. Recommendation 1.2.42 was adopted from the NICE guideline on child maltreatment. The committee added reference to collecting as well as administering treatments, based on their professional experience. Recommendation 1.2.43 was adopted from the NICE guideline on child maltreatment with no amendments. Recommendation 1.2.44 was adopted from the NICE guideline on child maltreatment with no amendments. Recommendation 1.2.45 was adopted from the NICE guideline on child maltreatment with no amendments. Recommendation 1.2.46 was adopted from the NICE guideline on child maltreatment with no amendments.

Topic/section heading	Supporting practitioners to recognise abuse and neglect
Recommendations	1.2.47 Ensure all practitioners working in primary care can recognise and respond to child abuse and neglect. Ways to achieve this include: • training newly qualified doctors in risk factors for abuse and neglect, such as parental mental health problems, alcohol and substance misuse (and providing top-up training sessions every 6 months) • giving information to parents and newly qualified practitioners, for example about local resources such as children's centres and parenting groups • completing a standardised questionnaire to screen for risk factors • providing access to a social worker where possible. 1.2.48 Ensure practitioners working in other community settings including education can recognise and respond to child abuse

	and neglect and are aware of child safeguarding guidance relevant to their profession, for example the Department for Education's Keeping children safe in education.
Research recommendations	What interventions are effective and cost effective in: • improving recognition by practitioners of children who are at risk of experiencing female genital mutilation (FGM) in the UK or overseas? • improving recognition of co-occurring forms of abuse where relevant? • preventing FGM in this group? What interventions are effective and cost effective in: • improving recognition by practitioners of children who are at risk of, or are experiencing, 'honour-based' violence and forced marriage? • preventing 'honour-based' violence and forced marriage? • What are the weaknesses in the statutory reporting system for child abuse and neglect?
Review questions	9. What is the impact of interventions aiming to provide early help to children and young people identified as at risk of child abuse and neglect?
Quality of evidence	The evidence for these recommendations was taken from the reviews of effectiveness of early help interventions. The evidence reviewed for this question comprised randomised control trials (RCTs) and systematic reviews of RCTs. The majority of included studies were given a moderate quality rating. Evidence of the effectiveness of clinic based interventions in early help was provided in 1 moderate quality systematic review, citing 1 US RCT.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations. For the recommendation relating to training, the committee noted that all professionals working with children should already receive some level of foundation and ongoing safeguarding training. The recommendation for top-up training may add to the resources needed for this, although it's likely to be minimal, and, the committee thought this was justified given the vital role of these professionals in this regard.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES18 (recommendations 1.2.47 and 1.2.48)
Other considerations	Recommendation 1.2.47 was based on ES18. This was based on an effectiveness study of a US intervention in which paediatricians working in primary healthcare settings were given training and resources to assist recognition. This was reviewed as part of the evidence on early help, but was later judged to be

	more relevant to recognition. The guideline committee thought that full intervention did not translate from a US to a UK context, but that key elements of the intervention were still applicable. Recommendation 1.2.48 extends the same principles to other practitioners, extrapolating from the evidence in ES18. The guideline committee also thought it was important to highlight that other professions have detailed guidance that they can follow in this area. The guideline committee also considered evidence on investigative interviewing protocols (ES136 and 137) and screening in hospital emergency departments (ES138) but there was no evidence of effectiveness found within this review.

Topic/section heading	Recognising child trafficking
Recommendations	1.2.49 Recognise that there are many reasons why children and young people may be trafficked other than for sexual exploitation. Other forms of exploitation include: • forced marriage • domestic servitude • working for low or no pay, or in illegal industries • being used for benefit fraud. 1.2.50 Recognise that both girls and boys can be trafficked and that children and young people from the UK can be trafficked, as well as those from other countries. 1.2.51 If you suspect a child or young person may have been trafficked: • ensure that concerns about their age and immigration status do not override child protection considerations • recognise that choosing an interpreter from the child's community may represent to them the community that has exploited them • aim to ensure continuity with the same interpreter, keyworker or independent advocate.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.
Review questions	6. What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action? 20. What aspects of professional practice and ways of working support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect? With relevant material from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or

	intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	The evidence for these recommendations was taken from: • the review of what helps and hinders professional practice in relation to recognition. The evidence comprised qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners, which were of mixed quality. • the review of what helps and hinders professional practice in responding to abuse and neglect. The evidence reviewed for this question included mixed methods and qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. These studies were of mixed quality. The evidence on child trafficking from across the 2 questions was provided in 2 good quality UK qualitative studies and 1 poor quality UK qualitative study.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES150 (recommendations 1.2.49, 1.2.50) ES172 (recommendation 1.2.51)
Other considerations	Recommendations 1.2.49 and 1.2.50 were based on ES150, which highlighted some of the barriers in professional practice in relation to child trafficking, including misconceptions of the issue. The guideline committee drew on the research papers on which this evidence statement is based to highlight some of the common misconceptions. These recommendations, particularly 1.2.50, also drew on the expert witness testimony, which highlighted the importance of recognising internal trafficking. Recommendation 1.2.51 was based on ES172 which highlighted practitioner views on good practice in relation to child trafficking. This was supported by testimony from the expert witness on child trafficking, which highlighted issues relating to continuity of involvement with trafficked children and young people.

Topic/section heading	Carrying out assessment – involving children, young people and families
Recommendations	1.3.1 Practitioners leading the assessment should ensure that all significant adults, children and young people in the family are involved. This means: • finding out their views and wishes • taking time to understand family relationships and dynamics. Exceptions are adults who could affect the nature of a criminal investigation, for example in cases of sexual abuse, induced illness, serious physical abuse or neglect and forced marriage. 1.3.2 As part of the assessment, collect and analyse information about all significant people in the child's care environment. The assessment should include each person's: • family, personal, social and health history, and • experiences of being parented. 1.3.3 When assessing a child or young person for abuse and neglect, practitioners should: • observe the child or young person • communicate directly with them • explore in a non-leading way any presenting signs of child abuse and neglect. Do not rely solely on information from the parent or carer in an assessment. See also recommendations 1.1.1 to 1.1.12 about working with children, young people, parents and carers. 1.3.4 When assessing a child or young person follow the principles in recommendation 1.1.3 and also: • keep them involved and informed at every stage of assessment and decision-making • tailor communication to their specific needs (see recommendation 1.1.2) • reinforce that they have a right to talk about any abuse or neglect and to seek help. 1.3.5 Provide training in communication skills to enable practitioners assessing children and young people to identify and interpret signs of abuse and neglect. 1.3.6 Practitioners should adopt an individualised approach to assessment that takes into account each child or young person's specific needs.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.
Review questions	6. What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action?

	8. What aspects of professional practice support and hinder effective assessment of risk and need in relation to child abuse and neglect? 20. What aspects of professional practice and ways of working support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect? With relevant material from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	The evidence for these recommendations was drawn from: • the review of what helps and hinders professional practice in relation to recognition. The evidence comprised qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners, which were of mixed quality. • the review of what helps and hinders professional practice in relation to assessment. The evidence reviewed for this question comprised qualitative studies, including studies of the views and experiences of children, young people, adult survivors parents, carers and practitioners, which were of mixed quality. • the review of what helps and hinders professional practice in responding to abuse and neglect. The evidence reviewed for this question included mixed methods and qualitative studies, including studies of the views and experiences of children, young people, adult survivors parents, carers and practitioners. These studies were of mixed quality. Evidence on understanding social history in assessment was drawn from 3 moderate quality UK serious case review syntheses, 1 moderate quality UK qualitative study and 1 poor quality UK thematic inspection study. Evidence on involving children and young people in assessment was drawn from 1 moderate quality UK serious case review synthesis, 1 moderate quality UK qualitative study and 1 poor quality UK thematic inspection study. Evidence on involving parents, caregivers and families in assessment was drawn from 1 moderate quality UK serious case review synthesis, 1 moderate quality UK qualitative study and 2 poor quality UK qualitative studies. Evidence on involving disabled children in assessment was taken from 1 moderate quality UK qualitative study.

Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations. Most of the above recommendations were considered to be in line with current practice and was considered important for recognition. For the recommendation relating to training, the committee considered whether this would require additional resources. They agreedthat this aspect of practice could be included within existing training opportunities, and therefore resource impact was likely to be minimal.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES126 (recommendation 1.3.2) ES127 (recommendation 1.3.3, 1.3.4) ES128 (recommendation 1.3.1) ES143 (recommendation 1.3.4) ES164 (recommendation 1.3.2) ES165 (recommendation 1.3.5)
Other considerations	The evidence underpinning recommendation 1.3.1 noted the importance of involving the whole family in the assessment process. However, the guideline committee noted that this would not be appropriate for some forms of abuse, as involving significant adults may mean involving the abuser, and alert them that their behaviour is under scrutiny. This could lead to negative consequences for the young person, or could obstruct evidence-gathering as part of bringing a criminal prosecution. The expert witness of forced marriage also highlighted that 'whole family' approaches may not be appropriate in this context. For recommendation 1.3.2, the evidence reviewed highlighted that assessment can be hindered by poor consideration of family 'social history'. The guideline committee thought that the concept of social history should include adults' own experiences of being parented, as a way of helping them to understand their own parenting behaviours. The evidence for recommendation 1.3.3 highlighted the importance of speaking to, and observing, children and young people directly. The guideline committee discussed the importance of doing this in such a way that does not contaminate any future court proceedings, and so added reference to any communication being 'non-leading'. The evidence for recommendation 1.3.4 was supported by feedback from the children and young people's expert reference group, who highlighted the importance of being kept involved during assessment, and about the results of assessment. The young people had also discussed how difficult it can be to talk about abuse or neglect. The second bullet point therefore encourages practitioners to provide positive reinforcement to children and young people, to reassure them that they have done the right thing. The evidence underpinning recommendation 1.3.5 highlighted that lack of ability to respond to children's communication needs

	can inhibit assessment. The guideline committee thought that this was best addressed through training, and equipping practitioners with the necessary skills. Recommendation 1.3.6 was a consensus recommendation, based on the guideline committee's professional experience. The guideline committee also considered evidence on the effectiveness of 2 structured tools for undertaking assessment (actuarial risk assessment ES124, California Family Risk Assessment ES125) but there was no evidence of effectiveness. Qualitative evidence on the Graded Care Profile (ES133) and London Safeguarding Board Trafficked Children Toolkit (ES134) was considered insufficiently strong to support a recommendation.

Topic/section heading	Carrying out assessment – factors to consider and developing a plan
Recommendations	1.3.7 Communicate concerns honestly to families about child abuse and neglect, taking into account confidentiality. Think about what information should be shared, and with whom, to avoiding placing the child at risk of further harm. 1.3.8 During assessment, focus primarily on the child's needs but also remember to: • address both the strengths and weaknesses of parents and carers and acknowledge that parenting can change over time • focus attention equally on male and female parents and carers. 1.3.9 1.3.9 Analyse the information collected during assessment and use it to develop a plan describing what services and support will be provided. This should be agreed with the child and their family (also see recommendation 1.1.6). Analysis should include evaluating the impact of any risk factors. 1.3.10 Organisations should ensure that practitioners conducting assessment in relation to abuse or neglect of disabled children or young people can access a specialist with knowledge about those children and young people's specific needs and impairments.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.
Review questions	8. What aspects of professional practice support and hinder effective assessment of risk and need in relation to child abuse and neglect? With relevant material from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?

Quality of evidence	The evidence for these recommendations was drawn from the review of what helps and hinders professional practice in relation to assessment. The evidence reviewed for this question comprised qualitative studies, including studies of the views and experiences of children, young people, adult survivors parents, carers and practitioners, which were of mixed quality. Evidence on involving parents, caregivers and families in assessment was drawn from 1 moderate quality UK serious case review synthesis, 1 moderate quality UK qualitative study and 2 poor quality UK qualitative studies. Evidence on the focus of assessment was drawn from 1 moderate quality UK qualitative study and 1 poor quality UK thematic inspection. Evidence on analysing information in assessments was taken from 3 moderate quality UK serious case review syntheses. There were 2 poor quality UK qualitative studies of caregiver views on assessment.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations. For recommendation 1.3.10 the committee considered that this would not require additional resource, as disabled children will already have people involved with them who have knowledge about their impairments. This recommendation focuses on ensuring that practitioners involved in any safeguarding work are able to contact and work with practitioners involved due to the child or young person's impairments.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES128 (recommendation 1.3.7) ES129 (recommendation 1.3.8) ES130 (recommendation 1.3.9) ES132 (recommendation 1.3.7) ES165 (recommendation 1.3.10)
Other considerations	Recommendation 1.3.7 was based on ES128 and ES132. The guideline committee also thought it was important to balance being honest about concerns with issues of confidentiality, and also working with parents who may conceal aspects of their behaviour. This was supported by the expert witness on forced marriage. Recommendation 1.3.8 was based on ES129. The evidence was also supported by the guideline committee's professional experience. The committee also noted that assessments can sometimes be 'side-tracked' by a focus on parental difficulties and lose focus on the child. Recommendation 1.3.9 was based on ES130 and supported by the guideline committee's own experience of practice challenges in relation to analysis of information gathered during assessment. Recommendation 1.3.10 was based on the evidence statement, and the guideline committee's professional experience that underlying impairments can sometimes mask abuse or neglect, or make it more difficult to identify and assess.

Topic/section heading	Early help – home visiting
Recommendations	1.4.1 Consider a programme of home visits, lasting at least 6 months, for parents or carers at risk of abusing or neglecting their child or children. This includes parents or carers with previously confirmed instances of abuse and neglect. 1.4.2 Identify parents and carers who would benefit from a programme of home visits during pregnancy or shortly after birth where possible. 1.4.3 Ensure that the programme of home visits includes: • support to develop positive parent–child relationships, including: • helping parents to understand children's behaviour more positively • modelling positive parenting behaviours • observing and giving feedback on parent–child interactions • helping parents to develop problem-solving skills • support for parents with substance misuse and mental health difficulties • support for parents to access relevant services, including healthcare, early years, educational services and other community services. 1.4.4 Ensure that the programme of home visits is delivered by either a health or social care practitioner or another worker who has been trained in delivering that particular home visiting programme.
Research recommendations	What are the components of effective home visiting interventions for prevention of child abuse and neglect in families of children and young people at risk of abuse and neglect in the UK?. What interventions are effective and cost-effective in a UK context in preventing abuse or neglect of children, young people and families at risk of, or showing early signs of, abuse and neglect? What is the impact of social isolation on children, young people and families at risk of abuse and neglect in the UK? What interventions are effective and cost-effective in a UK context in reducing social isolation and any associated child abuse and neglect? What interventions are effective and cost effective in: • improving recognition by practitioners of children who are at risk of experiencing female genital mutilation (FGM) in the UK or overseas? • improving recognition of co-occurring forms of abuse where relevant? • preventing FGM in this group? What interventions are effective and cost effective in:

	• improving recognition by practitioners of children who are at risk of, or are experiencing, 'honour-based' violence and forced marriage? • preventing 'honour-based' violence and forced marriage?
Review questions	9. What is the impact of interventions aiming to provide early help to children and young people identified as at risk of child abuse and neglect? With relevant material from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	The evidence for recommendations 1.4.1 to 1.4.4 was taken from the reviews of effectiveness of early help interventions. The evidence reviewed for this question comprised randomised control trials (RCTs) and systematic reviews of RCTs. The majority of included studies were given a moderate quality rating. Evidence relating to the effectiveness of home visiting programmes was provided in 1 moderate quality systematic review of reviews citing 3 relevant reviews (96 studies in total), 2 moderate quality systematic reviews (20 studies in total), 1 moderate quality UK RCT, 1 moderate quality Dutch RCT, 6 moderate quality US RCTs and 1 poor quality US RCT. The cost-effectiveness evidence included an additional good quality systematic review (12 studies). This evidence was therefore mostly of moderate quality. Many of the studies were not given the highest rating because they were conducted in areas other than the UK (mainly the USA and Australia), which the guideline committee judged to have substantially different practice contexts in relation to early help. Many studies also provided relatively sparse information regarding the content of the intervention. As noted in the economic analyses, there was also significant variation in sample characteristics and study design across studies, making it difficult to compare results. Recommendation 1.4.3 also drew on evidence taken from the review of what helps and hinders professional practice in relation to early help. The evidence reviewed for this question comprised largely qualitative studies, and integrated studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. The quality of evidence for the overall question was mixed, with 8 of 19 studies rated poor and the remainder moderate. The evidence on family satisfaction with home visiting was based on 2 moderate quality studies, 1 German and 1 from the USA.
Economic considerations	Additional economic analysis was undertaken on home visiting interventions. However, it was not possible to undertake a full

	economic analysis because even though the evidence base was large, the studies were too heterogeneous in terms of sample characteristics, intervention and comparison groups, time horizons, and outcomes measured. Although the economic analysis was inconclusive, the view of the committee was that home visiting was a commonly provided model of care which would not require significant additional investment. The full report is available in Economic Appendix C3.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES1 (recommendation 1.4.1, 1.4.2, 1.4.3, 1.4.4) ES2 (recommendation 1.4.1, 1.4.2, 1.4.3, 1.4.4) ES3 (recommendation 1.4.1, 1.4.2, 1.4.3, 1.4.4) ES4 (recommendation 1.4.1, 1.4.2, 1.4.3, 1.4.4) ES5 (recommendation 1.4.1, 1.4.2, 1.4.3, 1.4.4) ES22 (recommendation 1.4.3) EcES1 (recommendation 1.4.1, 1.4.2, 1.4.3, 1.4.4)
Other considerations	The effectiveness evidence in relation to home visiting evidence was mixed, with some studies finding an effect of the intervention on our outcomes of interest (including our primary outcome, incidence of abuse and neglect), and some studies finding no effect. We were unable to establish a clear relationship between features of the intervention and effectiveness. However, given that many of the studies did show the intervention to be effective, the guideline committee decided to make a weaker 'consider' recommendation for these interventions. The economic analysis was inconclusive, however the view of the committee was that home visiting was a commonly provided model of care which would not require significant additional investment. The recommended duration of the programme of visits (see recommendation 1.4.1) was based on the fact that only 1 of the included interventions lasted less than 6 months. The others ranged from 6 to 63 months, but there was no clear relationship between length of intervention and effectiveness. Identification of families during pregnancy or after birth (see recommendation 1.4.2) was a feature of the majority of effective interventions. The recommended features of the intervention (see recommendation 1.4.3) are based on an analysis of the most frequently occurring features of the included interventions, which were then refined and endorsed by the guideline committee. Breastfeeding support, which was a feature of a number of included interventions, was not recommended as the committee's view was that this did not have a clear link to abuse and neglect. A focus on parenting was also recommended in the 2 studies of parent experience of home visiting we examined. Recommendation 1.4.4 was based on the finding that effective interventions were delivered by either professionally qualified staff or trained paraprofessionals. This view was also supported by members of the guideline committee. The guideline committee also carefully considered evidence on parent-child interaction therapy at the early help stage (ES10 to

	12), multi-modal interventions (ES13 and EcES2), intensive family preservation services (ES16) and social support programmes (ES17). In each case there was either no evidence of effectiveness, or the evidence was considered too weak to make a recommendation.

Topic/section heading	Early help – parenting programmes
Recommendations	1.4.5 Consider a parenting programme for parents or carers at risk of abusing or neglecting their child or children. Tailor parenting programmes to the specific needs of the family (see recommendations 1.4.7 to 1.4.10). 1.4.6 When selecting parenting programmes think about whether parents or carers would benefit from help to: • develop skills in positive behaviour management • address negative beliefs about the child and their own parenting • manage difficult emotions, including anger. 1.4.7 Consider the Enhanced Triple P (attributional retraining and anger management) programme for mothers (of children aged 2 to 7) experiencing anger management difficulties. 1.4.8 Consider the Parents Under Pressure programme for mothers taking part in methadone-maintenance programmes. 1.4.9 Consider a Planned Activities Training programme, with or without mobile phone support, for vulnerable mothers (for example, those with a low level of education or income or aged under 18) of preschool children. 1.4.10 For parents or carers who have substance misuse problems, include content in the parenting programme to help them address their substance misuse in the context of parenting.
Research recommendations	What interventions are effective and cost-effective in a UK context in preventing abuse or neglect of children, young people and families at risk of, or showing early signs of, abuse and neglect? What is the impact of social isolation on children, young people and families at risk of abuse and neglect in the UK? What interventions are effective and cost-effective in a UK context in reducing social isolation and any associated child abuse and neglect? What interventions are effective and cost effective in:

	• improving recognition by practitioners of children who are at risk of experiencing female genital mutilation (FGM) in the UK or overseas? • improving recognition of co-occurring forms of abuse where relevant? • preventing FGM in this group? What interventions are effective and cost effective in: • improving recognition by practitioners of children who are at risk of, or are experiencing, 'honour-based' violence and forced marriage? • preventing 'honour-based' violence and forced marriage?
Review questions	9. What is the impact of interventions aiming to provide early help to children and young people identified as at risk of child abuse and neglect?
Quality of evidence	The evidence for these recommendations was taken from the reviews of effectiveness of early help interventions. The evidence reviewed for this question comprised randomised control trials (RCTs) and systematic reviews of RCTs. The majority of included studies were given a moderate quality rating. Evidence of the effectiveness of parenting programmes was provided in 1 moderate quality systematic review of reviews and 3 moderate quality RCTs, 2 from the USA and 1 from Australia. The cost-effectiveness analysis considered an additional moderate quality Australian RCT. Several of the studies were not given the highest rating because they were conducted in areas other than the UK (mainly the USA and Australia), which the guideline committee judged to have substantially different practice contexts in relation to early help. Evidence about tailoring parenting programmes was provided in 1 good quality US qualitative study.
Economic considerations	There was a lack of suitable economic evidence to inform these guideline recommendations. The guideline committee therefore based their recommendations on the effectiveness evidence interpreted in the context of their own experience. Although much of the effectiveness evidence was from outside the UK, the contexts were considered sufficiently similar to be extrapolated to the UK. The committee also took in consideration the fact that parenting programmes are already offered in many areas.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES6 (recommendations 1.4.5 to 1.4.10) ES7 (recommendations 1.4.5 to 1.4.10) ES8 (recommendations 1.4.5 to 1.4.10) ES9 (recommendation 1.4.5) ES14 (recommendations 1.4.5 to 1.4.10) ES15 (recommendations 1.4.5 to 1.4.10) EcES3 (recommendations 1.4.5 to 1.4.10)
Other considerations	Recommendations 1.4.5 to 1.4.10 were based on review of evidence in relation to a range of specific parenting programmes. Although the majority of evidence came from areas other than the UK, the committee were satisfied that the service context was sufficiently similar to extrapolate this evidence to a UK context.

	With regard to resource impact it was noted that parenting programmes are already offered in a many areas. Given the effectiveness evidence and their own professional experience, the committee decided to make an overarching recommendation relating to parenting programmes, as well as recommending 3 specific programmes (1.4.7, 1.4.8, 1.4.9) which were shown to be effective for particular groups. The overarching recommendation relates to parents generally (mothers and fathers). Although the majority of included studies involved female caregivers, the guideline committee considered it appropriate to extrapolate this evidence to male caregivers. Although the cost-effectiveness evidence was inconclusive in this area, the guideline committee's view was that parenting programmes are already often provided, and so implementation would not require significant investment. The description of what parenting programmes should address in recommendation 1.4.6 was derived from based on an analysis of the most frequently occurring features of the included interventions, which were then refined and endorsed by the committee. Recommendation 1.4.10 that parenting programmes for parents with substance misuse problems should include a focus on these issues was derived from the content of several included parenting programmes. These suggested that being a parent can provide good motivation for adults to address their substance misuse problems, but also that parents may need support to ensure that parenting stresses do not lead them to relapse. The guideline committee also considered evidence on parent–child interaction therapy at the early help stage (ES10 to 12), multi-modal interventions (ES13 and EcES2), intensive family preservation services (ES16) and social support programmes (ES17). In each case there was either no evidence of effectiveness, or the evidence was considered too weak to make a recommendation.

Topic/section heading	Early help – supporting families and knowledge and skills
Recommendations	1.4.11 Offer support to families as part of building helpful working relationships with them. This could include: • practical support, for example help to attend appointments and details of other agencies that can provide food, clothes and toys • emotional support, including empathy and active listening, and help to develop strategies for coping. 1.4.12 Give families information about local services and resources that they may find useful. 1.4.13 Ensure that all practitioners working at the early help stage:

	• understand the parental risk factors for child abuse and neglect (see recommendations 1.2.9 to 1.2.10) • are aware of the possibility of escalation of risk, particularly if family circumstances change. 1.4.14 Ensure that practitioners understand how to work with families as a whole in order to better support children and young people.
Research recommendations	What interventions are effective and cost-effective in a UK context in preventing abuse or neglect of children, young people and families at risk of, or showing early signs of, abuse and neglect? What is the impact of social isolation on children, young people and families at risk of abuse and neglect in the UK? What interventions are effective and cost-effective in a UK context in reducing social isolation and any associated child abuse and neglect? What interventions are effective and cost effective in: • improving recognition by practitioners of children who are at risk of experiencing female genital mutilation (FGM) in the UK or overseas? • improving recognition of co-occurring forms of abuse where relevant? • preventing FGM in this group? What interventions are effective and cost effective in: • improving recognition by practitioners of children who are at risk of, or are experiencing, 'honour-based' violence and forced marriage? • preventing 'honour-based' violence and forced marriage?
Review questions	14. What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect? With relevant material from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	These recommendations drew on evidence taken from the review of what helps and hinders professional practice in relation to early help. The evidence reviewed for this question comprised largely qualitative studies, and integrated studies of the views, and experiences of children, young people, adult survivors, parents, carers and practitioners. The quality of evidence for the overall question was mixed. Evidence on provision of emotional support was provided by 6 qualitative studies of service users' views: 2 UK studies, 1 of

	moderate quality and 1 of poor quality; 3 moderate quality US studies gathering service user views; and 1 poor quality Australian study, 2 moderate quality US qualitative studies, 1 poor quality Australian study and 2 poor quality UK studies. Evidence on provision of practical support was provided by 6 qualitative studies of service users' views: 2 UK studies, 1 of moderate quality and 1 of poor quality, 3 moderate quality US studies gathering service users' views and 1 poor quality Australian study. Awareness of risk was discussed in 2 moderate quality serious case review syntheses and 1 moderate quality UK qualitative study.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations. The committee noted that the 'practical support' referred to in 1.4.11 can entail relatively low cost items, and therefore resource impact is likely to be low. They emphasised the benefits of this type of support in terms of helping to build trust as well as supporting families.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES4 (recommendation 1.4.12) ES23 (recommendation 1.4.11) ES24 (recommendation 1.4.11) ES27 (recommendations 1.4.13)
Other considerations	The evidence supporting recommendation 1.4.11 concurred with the professional experience of the guideline committee, which suggested that service users value both emotional and practical support as part of intervention from services. Reference to practical support was linked to the committee's consideration of socio-economic factors and the role they can play in abuse and neglect. Recommendation 1.4.12 was based on ES4 and highlights the role that practitioners working at the early help stage can have in helping families to make use of universal community resources that are available to them. The committee's professional experience also supported the evidence underpinning recommendation 1.4.13, which was derived from syntheses of serious case review data. The committee thought it was important to stress that those providing early help interventions needed to have a good understanding of risk factors and indicators of abuse and neglect, in order to be able to escalate concerns as necessary. Recommendation 1.4.14 was a consensus recommendation. The professional experience of Committee members suggested that it was important to take in to account relationships and dynamics across the whole family when working to prevent abuse and neglect of children. The committee thought that this did not always happen in practice.

Topic/section heading	Response and support following abuse and neglect
Recommendations	1.5.1 After making a child protection referral: • do not relinquish responsibility for the referral • follow up the referral • ensure action takes place. You should expect to hear back from children's social care whether or not action has been taken, and the timescale of this action. If there is no action, follow local escalation policies if needed. 1.5.2 Practitioners working with families in which a child is involved in statutory child protection processes should: • take part in case conferences and meetings about the child • have an initial meeting with relevant practitioners to agree roles, responsibilities and ways of working, and to share information • build relationships with other practitioners working with that family • make sure all stakeholders can keep in touch with each other about the child • organise handovers if new staff members become involved • ensure actions are completed. 1.5.3 Ensure that all children and young people who have been abused or neglected are given a minimum of: • a safe place to live • an opportunity to be actively listened to and believed • support to explore aspects of their experience and express their feelings • early emotional support, including building emotional resilience and strategies for coping with symptoms such as nightmares, flashbacks and self-harm • support to reduce the risk of further abuse where appropriate, for example if a young person is at risk of sexual exploitation.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.
Review questions	21. What organisational factors support and hinder effective multi-agency working including supporting good professional judgement? With relevant information from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or

	intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	Recommendations 1.5.2 and 1.5.3 drew on the evidence review on organisational factors to support multi-agency practice. The evidence reviewed for this question comprised qualitative studies and syntheses of serious case review data. These were mostly of good or moderate quality. Evidence on initial response drew on 1 good quality UK qualitative study, 1 moderate quality UK qualitative study, 1 poor quality UK qualitative study and 2 moderate quality UK serious case review syntheses.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations. Participation in statutory child protection processes is already expected practice, and therefore resource impact was assessed as low, although the committee recognised noted
Evidence statements – numbered evidence statements from which the recommendations were developed	ES181 (recommendations 1.5.1 and 1.5.2)
Other considerations	Recommendations 1.5.1 and 1.5.2 were based on ES181, supported by Guideline Committee experience of common barriers to referring concerns about children and young people, and obtaining an initial response. The guideline committee were keen to highlight the responsibility of the referrer in following up referrals to children's social care. Recommendation 1.5.3 was a consensus recommendation. This was formulated in response to the fact that many of the therapeutic interventions recommended in section 1.7 are provided in response to symptoms or distress. It was the opinion of the committee that a response should be provided to all children and young people who have experienced abuse or neglect, regardless of whether they are currently showing symptoms or distress. It was the view of the committee that provision of a baseline level of support could prevent the need for more resource-intensive interventions at a later stage. The committee also thought that the support described could be provided by individuals already working with an abused or neglected child or young person (for example, a social worker) and so would not require commitment of additional resources.

Topic/section heading	Response to domestic abuse, trafficking and forced marriage
Recommendations	1.5.4 Ensure that police officers responding to incidents of domestic abuse have the confidence and skill to communicate with children and young people when needed, and information on how to make a referral. 1.5.5 When working with children and young people who have been trafficked, provide: • safe accommodation • legal support • specialist and trained interpreters where needed • culturally appropriate mental health services. 1.5.6 If a child or young person may be being (or has been) forced to marry, take action and offer support from culturally sensitive services.
Research recommendations	What interventions are effective and cost effective in: • improving recognition by practitioners of children who are at risk of, or are experiencing, 'honour-based' violence and forced marriage? • preventing 'honour-based' violence and forced marriage?
Review questions	20. What aspects of professional practice and ways of working support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect? With relevant material from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	Recommendations 1.5.4 to 1.5.6 used evidence taken from the review of what helps and hinders professional practice in responding to abuse and neglect. The evidence reviewed for this question included mixed methods and qualitative studies of mixed quality. Evidence on responses to domestic violence came from 1 moderate quality UK qualitative study. Evidence on response to child trafficking came from 2 good quality UK qualitative studies. Evidence on response to forced marriage came from 1 moderate quality UK qualitative study.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations.

Evidence statements – numbered evidence statements from which the recommendations were developed	ES172 (recommendation 1.5.5) ES173 (recommendation 1.5.6) ES175 (recommendation 1.5.4)
Other considerations	For recommendation 1.5.4 the guideline committee thought that there is currently variability in police practice in relation to domestic abuse where children and young people are present or are part of the household. The view of the committee was that clearer guidelines and support for police officers would help them to respond. Recommendation 1.5.5 was also supported by evidence provided by the expert witness on child trafficking, which highlighted the importance of helping children to navigate the immigration, criminal justice and social care systems. Recommendation 1.5.6 was supported by evidence from the expert witness on forced marriage who highlighted a lack of awareness and understanding of the issue as a key barrier to effective response. The recommendation encourages practitioners to 'take action' in response to the evidence from the systematic review and expert witness that practitioners were not aware that they can, and should be taking action, particularly given that forced marriage is a criminal offence.

Topic/section heading	Therapeutic interventions for children and young people and their parents or carers
Recommendations	1.6.1 Discuss in detail with children, young people and their families any interventions you offer them, explaining what the intervention will involve and how you think it may help. 1.6.2 Give children, young people and their families a choice of proposed interventions where possible. Recognise that some interventions, although effective, may not suit that person or family. 1.6.3 Take into account the age and developmental stage of the child or young person when selecting interventions. 1.6.4 Offer an attachment-based intervention to parents or carers who have neglected or physically abused a child under 5. 1.6.5 Deliver the attachment-based intervention in the parent or carer's home and aim to:

	• improve how they nurture their child, including when the child is distressed • improve their understanding of what their child's behaviour means • help them respond positively to cues and expressions of the child's feelings • improve how they manage their feelings when caring for their child. 1.6.6 Consider child–parent psychotherapy for parents or carers and children under 5 if the parent or carer has physically or emotionally abused or neglected the child, or the child has been exposed to domestic violence. 1.6.7 Ensure that child–parent psychotherapy: • is based on the Cicchetti and Toth model • consists of weekly sessions (lasting 45–60 minutes) over 1 year • is delivered in the parents' home, if possible, by a therapist trained in the intervention • involves directly observing the child and the parent–child interaction • explores the parents' understanding of the child behaviour • explores the relationship between the emotional reactions of the parents and their perceptions of the child on the one hand, and the parents' own childhood experiences on the other hand. [This recommendation is adapted from NICE's guideline on children's attachment.]
Research recommendations	What interventions, approaches and methodologies provided by social care and voluntary sector services are effective and cost effective in the UK to prevent the occurrence and recurrence of abuse and neglect, and to improve the wellbeing of children, young people and families? What interventions are effective and cost effective when working with fathers and male carers to improve their parenting in families where children are being, or have been, abused or neglected? Are home visiting interventions effective and cost effective in improving parenting and preventing recurrence of abuse and neglect in families in which abuse or neglect is occurring or has occurred? What interventions, including family behaviour therapy, are effective and cost effective in improving parenting and preventing recurrence of neglect by parents or carers with substance misuse problems and whose children are on a child protection plan under the category of neglect in the UK? Are web-based parenting programmes effective and cost effective for improving parenting and preventing recurrence of abuse and neglect in families where abuse or neglect has occurred? What peer support programmes are effective and cost effective in improving the wellbeing of abused or neglected children?

Review questions	15. What is the impact of social and psychological interventions responding to child abuse and neglect?
Quality of evidence	The evidence for these recommendations was taken from the review of effectiveness of interventions responding to child abuse and neglect. The evidence reviewed for this question comprised randomised control trials (RCTs) and systematic reviews of RCTs. For the question overall, included studies were mostly rated as moderate, but with a substantial proportion rated as poor. Evidence on attachment-based interventions for parents was provided in 1 moderate quality systematic review citing 2 US RCTs, and 1 poor quality US RCT. Evidence on child–parent psychotherapy was provided in 1 systematic review citing 2 US RCTs and 1 moderate quality US RCT.
Economic considerations	No economic evidence was identified for these recommendations. However, the group did consider the resource implications of the recommendations and considered them justifiable to include. Both recommendations have also been adapted from existing NICE guidance on children's attachment. It was also noted that interventions which could potentially prevent children and young people from becoming looked after result in cost savings.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES31 (recommendations 1.6.4 and 1.6.5) ES32 (recommendations 1.6.4 and 1.6.5) ES37 (recommendations 1.6.6 and 1.6.7) ES38 (recommendations 1.6.6 and 1.6.7) ES39 (recommendations 1.6.6 and 1.6.7) ES91 (recommendations 1.6.4 and 1.6.5) ES92 (recommendations 1.6.4 and 1.6.5)
Other considerations	Recommendations 1.6.1 and 1.6.2 were developed by Guideline Committee consensus, using their professional experience and also the comments of the children and young people's expert reference group. The children and young people's commented that some interventions which the evidence suggested were effective had not been helpful to them personally, and in some cases had been re-traumatising. The guideline committee thought that this could potentially be avoided in practice by clearly explaining to children and young people (and, by extension, parents, carers) what an intervention might involve, so that they can make an informed decision about whether to accept the intervention. Recommendation 1.6.3 was a consensus recommendation, reflecting the differing evidence bases for children and young people of different ages. Recommendations 1.6.4 to 1.6.7 present a 'first line' and alternative intervention for parents who have neglected or physically abused a child under 5. The guideline committee considered the attachment intervention to have the stronger evidence base and was therefore recommended as the first line

	intervention. This was also in line with the recommendations in the NICE guideline on children's attachment. Recommendations1.6.4 and 1.6.5 were based on ES32 to 33 and 91 to 92. These studies were also considered in the NICE guideline on children's attachment. The guideline committee therefore based their description of the intervention on the description in recommendation 1.4.1 in that guideline. However, this Guideline Committee chose to describe this as an 'attachment-based' intervention rather than a video feedback programme as this was considered to be a better description of the principal feature of the intervention. Recommendations 1.6.6 and 1.6.7 were based on ES37 to 39. The same studies were also reviewed as part of the NICE guideline on children's attachment. The guideline committee therefore used the same description of the intervention for consistency. The guideline committee also considered evidence on a number of interventions that were not recommended. Comparing these interventions with those which are recommended was difficult, as no studies compared the interventions head to head. Instead, the guideline committee considered the relative strength of evidence for interventions intended for similar population groups. For children aged under 5 who have experienced abuse or neglect and are still living with their birth families, the guideline committee also considered evidence relating to resilient peer treatment (ES30), promoting first relationships (ES43 to 45), behavioural child management (ES46), the I-InTERACT web-based parenting programme (ES51), nurse home visitation (ES60), intensive family preservation interventions (ES192) and a 'kids club' intervention (ES193). In each case, there was either no evidence of effectiveness, or the evidence was considered too weak to make a recommendation. The guideline committee also considered a number of interventions for children who have experienced abuse or neglect and are still living with their birth families, where their age was unclear. These were cognitive behavioural therapy (ES47, 48 and 50), family behaviour therapy (ES49), the Incredible Years programme (ES53) and Project Support (ES61), Family Assessment Response (ES185, EcES4), wraparound facilitation (ES190) and an intensive family preservation intervention (ES192). In each case, there was either no evidence of effectiveness, or the evidence was considered too weak to make a recommendation.

Topic/section heading	Therapeutic interventions for older children and young people and their parents or carers
Recommendations	1.6.8 Consider a comprehensive parenting intervention for parents and children under 12 if the parent or carer has physically or emotionally abused or neglected the child. This should comprise weekly home visits for at least 6 months that address:

	• parent–child interactions • caregiving structures and parenting routines • parental stress • home safety • any other issues that caused the family to come to the attention of services. As part of the intervention, help the family to access other services they might find useful. 1.6.9 Consider parent–child interaction therapy for parents and children under 12 if the parent has physically abused or neglected the child. Combine group sessions for these parents with individual child–parent sessions, focusing on developing child-centred interaction and effective discipline skills. 1.6.10 Consider multi-systemic therapy for child abuse and neglect (MST-CAN) for parents, children and young people aged 10 to 17 if the parent has abused or neglected their child. This should: • involve the whole family • address multiple factors contributing to the problem • be delivered in the home or in another convenient location • include a round-the-clock on-call service to support families to manage crises.
Research recommendations	What interventions are effective and cost effective in improving the wellbeing of young people aged 12 to 17 who have experienced abuse or neglect, including those who are now in temporary or permanent alternative care placements? What interventions, approaches and methodologies provided by social care and voluntary sector services are effective and cost effective in the UK to prevent the occurrence and recurrence of abuse and neglect, and to improve the wellbeing of children, young people and families? What interventions are effective and cost effective when working with fathers and male carers to improve their parenting in families where children are being, or have been, abused or neglected? Are home visiting interventions effective and cost effective in improving parenting and preventing recurrence of abuse and neglect in families in which abuse or neglect is occurring or has occurred? What interventions, including family behaviour therapy, are effective and cost effective in improving parenting and preventing recurrence of neglect by parents or carers with substance misuse problems and whose children are on a child protection plan under the category of neglect in the UK? Are web-based parenting programmes effective and cost effective for improving parenting and preventing recurrence of abuse and neglect in families where abuse or neglect has occurred? What peer support programmes are effective and cost effective in improving the wellbeing of abused or neglected children?

Review questions	15. What is the impact of social and psychological interventions responding to child abuse and neglect?
Quality of evidence	The evidence for these recommendations was taken from the review of effectiveness of interventions responding to child abuse and neglect. The evidence reviewed for this question comprised randomised control trials (RCTs) and systematic reviews of RCTs. For the question overall, included studies were mostly rated as moderate, but with a substantial proportion rated as poor. The evidence on the parenting intervention (SafeCare) was provided by a moderate quality systematic review citing 1 large US RCT. The evidence on parent-child interaction therapy was provided by 1 moderate quality systematic review citing 3 RCTs, 2 US and 1 country unknown. Multi-systemic therapy was investigated in 1 moderate quality systematic review citing 1 RCT (country unknown) and 1 moderate-quality US RCT.
Economic considerations	The economists undertook economic modelling work in relation to recommendation 1.6.8. The UK-equivalent cost of the parenting (SafeCare) intervention per family for 6 months is between £3,500 and £6,000. The intervention led to an average 17% relative risk reduction (95% CI, 2% to 30%) in any report to child protective services, which was sustained over the next 5.5 years. We were unable to estimate the potential impacts on public sector costs or additional outcomes on children due lack of information. There was not enough evidence to assess the cost-effectiveness of the SafeCare intervention, given the lack of evidence to make links between reported outcomes and impact on QALYs or public sector costs. The full analysis for recommendation 1.6.8 can be found in economic Appendix C3. For the other recommendations, although there was no economic evidence, the guideline committee were mindful of potential costs and resource use. It was noted that foster carers would typically receive some type of support; these recommendations could therefore assist commissioners in selecting the most effective types.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES40 (recommendation 1.6.9) ES41 (recommendation 1.6.9) ES42 (recommendation 1.6.9) ES56 (recommendation 1.6.10) ES57 (recommendation 1.6.10) ES58 (recommendation 1.6.10) ES59 (recommendation 1.6.10) ES62 (recommendation 1.6.8)
Other considerations	Recommendations 1.6.8 and 1.6.9 present a ‘first line’ and alternative intervention for parents who have physically abused or neglected their child aged under 12. The ‘first line’ intervention had the stronger evidence (very large sample study n=2175). Recommendation 1.6.10 is an intervention for parents who have abused or neglected an older child (age 10 to 17). Recommendation 1.6.8 was based on ES62 related to SafeCare and the modelling work undertaken by the economist. The

	economic evidence was inconclusive, but the guideline committee made the recommendation based on the effectiveness evidence, which was based on a substantial RCT (n=2,175) supported by their own professional experience. The recommendation describes the characteristics of the intervention rather than using the specific name. Recommendation 1.6.9 was based on ES40 to 42. Although this intervention also had good evidence, it was weaker than the evidence for 1.6.8, including being based on smaller sample sizes. Recommendation 1.6.10 was based on ES56 to 59. Although the evidence for this intervention was relatively weak, a recommendation was made as there were relatively few interventions for older children and young people. The guideline committee also noted that the evidence suggested this intervention had good effectiveness in terms of reducing out of home placements. The guideline committee also considered evidence on a number of interventions that were not recommended. Comparing these interventions with those which are recommended was difficult, as no studies compared the interventions head to head. Instead, the guideline committee considered the relative strength of evidence for interventions intended for similar population groups. For children aged 5 and over who have experienced abuse or neglect and are still living with their birth families, the guideline committee also considered evidence relating to a child-focused adaptation of the Incredible Years programme (ES29), the I-InTERACT web-based parenting programme (ES51), a revictimisation prevention intervention (ES191). In each case there was either no evidence of effectiveness, or the evidence was considered too weak to make a recommendation. The guideline committee also considered a number of interventions for children who have experienced abuse or neglect and are still living with their birth families, where their age was unclear. These were cognitive behavioural therapy (ES47, 48 and 50), family behaviour therapy (ES49), the Incredible Years programme (ES53) and Project Support (ES61), Family Assessment Response (ES185, EcES4), wraparound facilitation (ES190) and an intensive family preservation intervention (ES192). In each case, there was either no evidence of effectiveness, or the evidence was considered weaker than the evidence for the interventions that were recommended.

Topic/section heading	Therapeutic interventions for foster carers, adoptive parents, children and young people
Recommendations	1.6.11 Offer an attachment-based intervention in the home to foster carers looking after children under 5 who have experienced abuse or neglect. Aim to help foster carers to:

	• improve how they nurture their foster child, including when the child is distressed • improve their understanding of what the child's behaviour means • respond positively to cues and expressions of the child's feelings • behave in ways that are not frightening to the child • improve how they manage their feelings when caring for their child. [This recommendation is adapted from the NICE guideline on children's attachment.] 1.6.12 Consider the attachment-based intervention in recommendation 1.6.11 for adoptive parents and those providing permanence (including special guardians, foster carers or kinship carers) for children under 5 who have experienced abuse or neglect. 1.6.13 For foster carers of children aged 5 to 12 who have experienced abuse and neglect, consider a group-based parent training intervention that includes strategies to manage behaviour and discipline positively. This should include using video, roleplay and homework practice. 1.6.14 For foster carers, adoptive parents and those providing permanence for children and young people aged 5 to 17 who have experienced abuse or neglect, consider a trauma-informed group parenting intervention, using a trust-based relational intervention as an example. It should help to: • develop the child's capacity for self-regulation • build trusting relationships • develop proactive and reactive strategies for managing behaviour.
Research recommendations	What interventions are effective and cost-effective in improving the wellbeing of older young people (aged 12 to 17) who have experienced maltreatment, including those who are now in temporary or permanent alternative care placements, including (but not limited to) foster care, kinship care, residential care, special guardianship or adoption. Which social care and voluntary sector UK interventions, approaches and methodologies other than those recommended in these guidelines are effective and cost-effective in preventing occurrence/recurrence of abuse and neglect, and improving the wellbeing of children, young people and families? What interventions are effective and cost-effective in working with male foster carers and adoptive parents who are caring for children and young people who have been abused in the past? What is the relative effectiveness and cost-effectiveness of the KEEP intervention for foster carers of maltreated children compared to other interventions? What peer support programmes are effective and cost-effective in improving the wellbeing of maltreated children?
Review questions	15. What is the impact of social and psychological interventions responding to child abuse and neglect?

Quality of evidence	The evidence for these recommendations was taken from the review of effectiveness of interventions responding to child abuse and neglect. The evidence reviewed for this question comprised randomised control trials (RCTs) and systematic reviews of RCTs. For the question overall, included studies were mostly rated as moderate, but with a substantial proportion rated as poor. Evidence on attachment-based interventions for foster carers was provided in 1 moderate quality systematic review citing 2 US RCTs. Evidence on KEEP was provided in 1 moderate quality systematic review, citing 1 US RCT. Evidence on the trust-based relational intervention was provided by 1 moderate quality US RCT. All included studies were from the USA. However, the guideline committee thought that the context for delivery was sufficient to include this evidence.
Economic considerations	The economists undertook a cost-effectiveness analysis on recommendation 1.6.13 ('KEEP' intervention). The analysis finds that the KEEP intervention costs between £2,012 and £9,818 per foster carer, where costs are lower if delivered to a group of 10 foster carers by a family support worker, and are higher if delivered to a group of 3 foster carers by a child social worker. The KEEP intervention led to an increase in caregivers' use of positive parenting skills relative to the amount of discipline used and also led to a decrease in the number of child behaviour problems, where effects were greatest among children with higher numbers of behaviour problems. The cost-effectiveness findings are likely underestimates of the intervention's cost-effectiveness. Additional literature suggests there are additional benefits and cost savings to the child and to the public sector in the short, medium, and long term. However, we could not quantitatively include those impacts due to uncertainty regarding the exact magnitude of the effects. In conclusion, there is not enough evidence to assess the cost-effectiveness of the KEEP intervention, given the lack of evidence to make links between reported outcomes and impact on QALYs or public sector costs. The cost-effectiveness analysis for recommendation 1.6.13 can be found in economic Appendix C3. The guideline committee were mindful of those costs and potential impacts when making this recommendation. For the other recommendations, although there was no economic evidence, the guideline committee were mindful of potential costs and resource use.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES33 (recommendations 1.6.11 and 1.6.12) ES34 (recommendations 1.6.11 and 1.6.12) ES35 (recommendations 1.6.11 and 1.6.12) ES36 (recommendations 1.6.11 and 1.6.12) ES55 (recommendation 1.6.13) ES194 (recommendation 1.6.14)
Other considerations	Recommendations 1.6.11 to 1.6.14 present different options for interventions for alternative carers of children of different ages.

	Recommendations 1.6.11 and 1.6.12 were based on ES33 to 36. The description of the intervention is based on the description in the NICE guideline on children's attachment (recommendation 1.4.1) as both recommendations are based on the same studies. However, the guideline committee chose not to focus on the video guidance aspect of the interventions, but rather on the outcomes the intervention was aiming to achieve. The studies reviewed were with foster carers. However, the committee thought it was appropriate to extrapolate this evidence to a weaker recommendation for adoptive parents and other carers providing permanence for children under 5 (recommendation 1.6.12). Recommendation 1.6.13 was based on ES55 and the economic modelling work. The committee were satisfied that the US evidence could be extrapolated to a UK context for this recommendation. Although the economic modelling was inconclusive regarding the cost effectiveness of the intervention, the committee considered that the effectiveness evidence. interpreted in the context of their experience, was sufficient to support a recommendation. The characteristics of the intervention rather than the specific name has been used.The guideline committee also highlighted from their own experience the importance of supporting foster carers. Recommendation 1.6.14 was based on ES194. The original study was with adoptive parents of 5- to 12-year-olds. However, the guideline committee identified a gap in recommendations for alternative carers of children aged over 12 and identified this intervention as likely to be the most suitable for carers of young people aged 12 to 17, given the emphasis on trauma and the content of the intervention. The recommendation was therefore extended to all types of alternative carers, and to this older age group. The guideline committee also considered evidence relating to the Incredible Years programme for carers of fostered and adopted children (ES52, 54, EcES5). This intervention was not compared head to head with either of the recommended interventions, making comparisons of effectiveness difficult. However, the evidence for use of Incredible Years with foster carers (ES52) did not show an impact on child behaviour, unlike the KEEP intervention. The use of Incredible Years with adoptive parents resulted in a very small impact on child behaviour and wellbeing (ES54), whereas the trauma-based intervention showed better effect sizes. The study of Early Intervention Foster Care (ES186) examined placement breakdown only, and did not directly measure children and young people's wellbeing.

Topic/section heading	Therapeutic interventions after sexual abuse
Recommendations	1.6.15 Consider group or individual trauma-focused cognitive behavioural therapy for children and young people (boys and girls) who have been sexually abused and show symptoms of anxiety, sexualised behaviour or post-traumatic stress disorder. When offering this therapy:

	• discuss it fully with the child or young person before providing it, in light of the fact that some children and young people do not find this intervention helpful • make clear that there are other options available if they would prefer • provide separate sessions for the non-abusing parent or carer. 1.6.16 For children and young people (boys and girls) aged 8 to 17 who have been sexually abused, consider a programme, for example 'Letting the future in', that: • emphasises the importance of the therapeutic relationship between the child and therapist • offers support tailored to the child's needs, drawing on a range of approaches including counselling, socio-educative and creative approaches (such as drama or art) • includes individual work with the child (up to 20 sessions, extending to 30 as needed) and parallel work with non-abusing parents or carers (up to 8 sessions). 1.6.17 For girls aged 6 to 14 who have been sexually abused and who are showing symptoms of emotional or behavioural disturbance, consider one of the following after assessing carefully and discussing with the girl which option would suit her best: • individual focused psychoanalytic therapy (up to 30 sessions) or • group psychotherapeutic and psychoeducational sessions (up to 18 sessions). Provide separate sessions for the non-abusing parent or carer.
Research recommendations	What interventions are effective and cost-effective in improving the wellbeing of older young people (aged 12 to 17) who have experienced maltreatment, including those who are now in temporary or permanent alternative care placements, including (but not limited to) foster care, kinship care, residential care, special guardianship or adoption.
Review questions	16. What is the impact of social and psychological interventions responding to child sexual abuse? (Prevention of recurrence, prevention of impairment)
Quality of evidence	The evidence for these recommendation was taken from the review of effectiveness of interventions responding to child sexual abuse. The evidence reviewed for this question comprised randomised control trials (RCTs) and systematic reviews of RCTs of mixed quality. Evidence on cognitive behavioural therapy was provided in 1 good quality meta-analysis of 9 US and 1 Australian RCT, additional information from 1 moderate and 1 poor quality systematic review and 2 poor quality US RCTs. Evidence on Letting the Future In was provided in 1 moderate quality UK RCT. Evidence on individual and group psychotherapy was provided in 1 poor quality UK RCT.

Economic considerations	The economists undertook a cost–consequence analysis on Recommendation 1.6.15 (individual and group-based trauma-focused cognitive behaviour therapy – CBT). There were various delivery modes of trauma-focused CBT, which affect intervention costs. Costs were also significantly increased if supervision was included. The range of costs for group-based CBT is between £100 and £2,500 if supervision costs are excluded and between £300 and £6,800 if supervision costs are included. The range of costs for individual CBT is between £500 and £5,900 if supervision costs are excluded and between £1,800 and £18,700 if supervision costs are included. Trauma-focused CBT (T-CBT) was more effective than unstructured psychotherapy for the outcomes of post-traumatic stress disorder and anxiety and has weak evidence of effectiveness for depression. For the outcomes of child behaviour problems and sexual behaviour, T-CBT was not more effective than supportive unstructured psychotherapy. This cost–consequence analysis provides information about the additional costs of the intervention and how the intervention changes outcomes for children. In this sense, our cost-consequence analysis is missing additional information, such as the potential impact of the intervention on the child's use of public sector services, which would give this economic analysis a wider perspective. There was no information about wider impacts on service use and it was not possible to make links to QALYs. There is therefore not enough evidence to assess the cost-effectiveness of T-CBT compared to supportive unstructured psychotherapy. The full report on recommendation 1.6.15 is available in Economic Appendix C3. The guideline committee were mindful of the potential costs and resource use when making these recommendations. For the other recommendations, although there was no economic evidence, the guideline committee were mindful of potential costs and resource use.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES64 (recommendation 1.6.15) ES65 (recommendation 1.6.15) ES66 (recommendation 1.6.15) ES67 (recommendation 1.6.15) ES68 (recommendation 1.6.15) ES69 (recommendation 1.6.15) ES72 (recommendation 1.6.17) ES74 (recommendation 1.6.17) ES187 (recommendation 1.6.15) ES188 (recommendation 1.6.16) ES189 (recommendation 1.6.16) EcES6 (recommendation 1.6.16) EcES7 (recommendation 1.6.15)
Other considerations	Recommendation 1.6.15 was based on evidence statements ES64 to 69 and the economic modelling work on CBT. The intervention was shown to be less effective in reducing

	depressive symptoms, but was thought on balance to be effective. The effectiveness and economic evidence did not strongly favour either group or individual CBT, so this has been left to practitioner judgement. The effectiveness and economic evidence did not strongly favour any particular model of CBT, but the guideline committee's professional experience was that T-CBT would be most appropriate for this group. The guideline committee received strong feedback from the children and young people's expert reference group that they had not all found cognitive behavioural therapy to be helpful, and this was supported by some committee members' own professional experiences. The recommendation has therefore been worded to make it clear that the intervention should be discussed and explained, and other options offered (see recommendations 1.6.16 to 1.6.17). Recommendation 1.6.16 was based on ES188-189 and EcES6. The intervention was described in its evaluation as a psychodynamic intervention. However, the guideline committee thought that this term did not correctly describe the intervention. The recommendation describes the characteristics of the intervention rather than provide a label. The description of the intervention and recommended duration are based on the relevant study. The intervention was not recommended for the younger age group as the study found the intervention to be ineffective for this group. Recommendation 1.6.17 was based on ES72 and EcES6. Although the cost-effectiveness evidence suggested that group therapy was more cost-effective, the guideline committee thought that this should be left to professional judgement, as some children and young people may prefer individual therapy, whereas others would prefer to be in a group. The recommended target group (girls only), and duration, of the intervention is based on the relevant study. The committee considered whether to extrapolate this recommendation to boys as well as girls. However, in their professional experience the same interventions were not always effective for boys as for girls. The view of the committee was that it was therefore not appropriate to extend this recommendation to boys. Recommendations 1.6.15, 1.6.16 and 1.6.17 are all aimed at children who have experienced sexual abuse and are showing signs of distress. This was on the basis of the populations of the relevant studies, and because the guideline committee's professional experience suggested that intensive therapeutic intervention could be unnecessary or harmful if a young person is not showing signs of distress. The guideline committee also considered evidence on risk reduction family therapy (ES70) but there was insufficient evidence of effectiveness. The committee also considered evidence on an adapted version of prolonged exposure therapy (ES73). Although the evidence suggested this was effective, the guideline committee had concerns about the ethics of this treatment model, and a strong view was expressed by the children and young people's expert reference group that this type

	of treatment was not appropriate for people who have been sexually abused.

Topic/section heading	Planning and delivering services
Recommendations	1.7.1 Where possible, plan services in a way that enables children, young people, parents and carers to work with the same professionals over time. 1.7.2 For cases involving children not already subject to protection plans, agencies responsible for planning and delivering statutory child protection services should agree common terminology to describe multi-agency working arrangements, including: • • the terms used to describe meetings • defining who the lead practitioner is. 1.7.3 Agencies responsible for planning and delivering services for children should agree clear joint protocols for addressing abuse and neglect at the early help stage, and through statutory child protection processes. Ensure these: • • address less well-recognised forms of abuse, including child sexual exploitation, female genital mutilation, forced marriage and child trafficking, serious youth violence and gang membership • are communicated to all agencies, including those providing universal services. 1.7.4 Agencies must address obstacles to partnership working, including agreeing ways to support sharing information when it is in a child or young person's best interests, in line with statutory guidance given in Working together to safeguard children. (For additional advice on this see the Department for Education's Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers.) For example, allow agreed database access to staff from other agencies, or integrate teams from different agencies. 1.7.5 Ensure staff from different agencies who are working on the same, or related, cases or issues are co-located wherever possible. 1.7.6 To address the risks posed by sexual exploitation and gangs, agencies responsible for planning and delivering services for children and young people should ensure there is: • • effective leadership within agencies • • a local lead who will coordinate planning and information sharing between agencies.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.
Review questions	6. What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action?

	14. What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect? 20. What aspects of professional practice and ways of working support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect? 21. What organisational factors support and hinder effective multi-agency working including supporting good professional judgement? With relevant information from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	These recommendations draw on evidence from the reviews on: • what helps and hinders professional practice in relation to recognition. The evidence comprised qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners, which were of mixed quality. • what helps and hinders professional practice in relation to early help. The evidence reviewed for this question comprised largely qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. The quality of evidence for the overall question was mixed. • what helps and hinders professional practice in responding to abuse and neglect. The evidence reviewed for this question included mixed methods and qualitative studies, including studies of the views and experiences of children, young people, adult survivors, parents, carers and practitioners. These studies were of mixed quality. • organisational factors to support multi-agency practice. The evidence reviewed for this question comprised largely qualitative studies and syntheses of serious case review data. These were mostly of good or moderate quality. Evidence relating to continuity of relationships came from 4 good quality UK qualitative studies, 3 moderate quality UK qualitative studies and 3 poor quality UK qualitative studies. Evidence on terminology and use of protocols was provided in 2 moderate quality UK serious case review syntheses, 2 good quality UK qualitative studies, 1 moderate quality UK qualitative study, and 1 poor quality UK qualitative study.

	Evidence on partnership working was provided in 1 poor quality mixed methods study, 1 good quality UK qualitative study, 4 moderate quality UK studies, 1 moderate quality German study, 1 moderate quality US study and 2 poor quality UK studies. Evidence on use of IT systems was provided in 2 good quality UK qualitative studies and 2 moderate quality UK serious case review syntheses.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations. With regard to the recommendation on co-location, the committee noted that such arrangements were increasingly common (for example Multi-Agency Safeguarding Hubs) and may not require additional investment in many areas. They therefore considered this justifiable in terms of likely resource impact.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES26 (recommendation 1.7.4) ES140 (recommendation 1.7.1.) ES152 (recommendation 1.7.1) ES163 (recommendation 1.7.4) ES168 (recommendation 1.7.4) ES169 (recommendation 1.7.4) ES176 (recommendation 1.7.2) ES177 (recommendation 1.7.6) ES178 (recommendation 1.7.3) ES179 (recommendation 1.7.4) ES180 (recommendation 1.7.5)
Other considerations	Recommendation 1.7.1 was based on ES140 and 152, which highlighted the views of children and young people about developing trusting relationships with professionals, built up over time. This was supported by feedback from the children and young people's expert reference group who also highlighted the issue of trust, and being able to see the same professional over time. The guideline committee discussion highlighted that that continuity of relationships is something that would need to be addressed in service planning rather than by individual practitioners. Recommendation 1.7.2 was based on ES176 which cited findings from syntheses of serious case reviews that misunderstandings about terminology, particularly at the 'child in need' level, can hinder effective multi-agency working. The evidence, and the experience of the committee, suggested that whereas working arrangements were clear when a child was subject to a protection plan (child protection conferences interspersed with core group meetings), they were less clear, and more variable when children and young people were defined as 'in need' but not subject to a plan. The guideline committee thought that this could be tackled

	at a local strategic level by ensuring that common terminology is agreed and disseminated locally. Recommendation 1.7.3 was based on ES178 which highlighted the importance of clear local multi-agency protocols. The guideline committee highlighted in particular the need for agreed ways of working in relation to less well-recognised and understood forms of abuse, including child sexual exploitation, female genital mutilation, forced marriage and child trafficking, serious youth violence and gang membership. Recommendation 1.7.4 was based on ES26, 168, 169 and 179, all of which highlighted the importance of partnership and multi-agency working, including information-sharing. Several of the evidence statements cited failure to share information as a barrier to effective practice (ES168, 179). The guideline committee thought that the importance of multi-agency working was well known in the sector, and so focused the recommendation on addressing obstacles to this, including information-sharing. ES179 and the guideline committee's own experience suggested that access to IT systems was often a barrier. However, the committee also noted that integrated teams (for example, multi-agency safeguarding hubs) were often a way to address this, as people could ask colleagues for information from their IT system, rather than needing access to the system itself. Recommendation 1.7.5 was based on ES180. The guideline committee's experience also supported the benefits that co-locating teams can provide, including their experience of effective local arrangements such as multi-agency safeguarding hubs. Recommendation 1.7.6 was based on ES177 which highlighted the importance of leadership and strategic planning in relation to child sexual exploitation and gangs. The guideline committee considered recent examples of high profile child sexual exploitation cases and concurred with the evidence that this was an issue that required clear local leadership.

Topic/section heading	Supervision and support for staff
Recommendations	1.7.7 For staff working in child protection from different agencies who are co-located, provide ongoing opportunities to: • maintain their professional skills and competencies • stay in touch with colleagues from their own professional discipline. 1.7.8 Organisations should support staff working with children and families at risk of or experiencing abuse, and ensure they have access to good quality supervision. This should include: • case management • reflective practice • emotional support • continuing professional development.
Research recommendations	The guideline committee did not prioritise this as an area on which to make research recommendations.

Review questions	21. What organisational factors support and hinder effective multi-agency working including supporting good professional judgement? With relevant material from: 1. What are the views and experiences of children and young people, their caregivers and families, and adult survivors of child abuse in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people? 2. What are the views and experiences of practitioners working in the UK on the process of recognising and assessing abuse and neglect, and on services providing early help for, or intervention following, abuse and neglect of children and young people?
Quality of evidence	Recommendation 1.7.8 drew on the evidence review on organisational factors to support multi-agency practice. The evidence reviewed for this question comprised qualitative studies and syntheses of serious case review data. These were mostly of good or moderate quality. Evidence on supervision was provided by 1 moderate quality UK qualitative studies, 1 poor quality UK qualitative study and 2 moderate quality UK serious case review syntheses.
Economic considerations	Although no economic evidence was available to inform these guideline recommendations, the guideline committee were mindful of potential costs and resource use when making the recommendations.
Evidence statements – numbered evidence statements from which the recommendations were developed	ES182 (recommendation 1.7.8)
Other considerations	Recommendation 1.7.7 was a consensus recommendation made on the basis of the guideline committee's expertise and experience. The committee wanted to make particular reference to continuing professional development and professional identity of co-located staff. Whilst co-location and integration are beneficial, the disadvantage can be a loss of professional identity and associated continuing professional development. Recommendation 1.7.8 was based on ES182 regarding the influence of supervision on the quality of work. Detail from the Brandon et al. (2013 +) study and the guideline committee's experience were used to develop the 4 listed features of good quality supervision.

4 Implementation: getting started

Some issues were highlighted that might need specific thought when implementing the recommendations. These were raised during the development of this guideline. They are:

- Offering effective therapeutic interventions for children and their parents or carers. Although families who have children on child protection plans usually receive interventions from a social worker, there is currently a lack of provision of evidence-based therapeutic interventions to support parents, carers, foster carers and adoptive parents to meet the needs of children who have been abused or neglected.
- Providing more training and education for all staff who work with children who have experienced abuse and neglect. Training in recognising the signs of abuse and neglect and when to act on them is a priority, particularly as new forms of abuse emerge. However, increasing training is likely to prove challenging for many organisations because of cuts in resources.
- Making multi-agency responses effective across the country. It should begin at the early help stage. Adopting common language and terms, leadership at all levels, agreeing protocols for information sharing and co-locating staff from different agencies who are working on the same, or related, cases or issues all contribute to effective multi-agency working.

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes recommended for practice that can be done quickly – such as conducting a baseline assessment (see 3 below) – should be shared quickly. This is because health and social care professionals should use guidelines to guide their work and keep their skills and knowledge up to date – as is required by professional regulating bodies such as the Health and Care Professions Council, General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. Raise awareness through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. Identify a lead with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. Carry out a baseline assessment against the recommendations to find out whether there are gaps in current service provision.

4. Think about what data you need to measure improvement and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. Develop an action plan, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. For very big changes include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. Implement the action plan with oversight from the lead and the project group. Big projects may also need project management support.

8. Review and monitor how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

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6 Related NICE guidance

To find out what NICE has said on topics related to this guideline, see our web pages on

Post-traumatic stress disorder: management NICE guideline CG26 (2005)

Child maltreatment: when to suspect maltreatment in under 18s NICE guideline CG89 (2009)

Domestic violence and abuse: multi-agency working NICE guideline PH50 (2014)

Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care NICE guideline NG26 (2015)

Harmful sexual behaviour among children and young people NICE guideline NG55 (2016)

7 Contributors and declarations of interests

Members of the Committee and other contributors to the guideline declared any relevant interests. [Add guideline number to hyperlink] in line with the conflicts of interest policy.

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The following members of the Guideline Development Group made declarations of interest. All other members of the Group stated that they had no interests to declare.

Committee member	Interest declared	Type of interest	Decision taken
Corinne May-Chahal	Panel member on the Responsible Gambling Trust Treatment Panel	Personal financial (non-specific)	No action needed
Corinne May-Chahal	Received an EU grant to do work around trafficking exploitation involving adults, children and young people	Non-personal financial (non-specific)	No action needed
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8 Glossary and abbreviations

Glossary

Abuse and neglect

In this guideline abuse and neglect includes inflicting harm on a child or young person and also failing to protect them from harm. Children and young people may be abused by someone they know in a family or in an institutional or community setting or, more rarely, by someone they don't know (for example through the internet).

Analysis

Analysis involves organising the information collected during assessment, judging its significance and exploring different perspectives, to identify themes and reach conclusions on what these mean for the child or young person and their family. It should draw on knowledge from research and practice combined with an understanding of the child's needs.

Attachment-based intervention

Interventions which are based on attachment theory. Attachment-based interventions focus on improving the relationships between children and young people and their key attachment figures (often, parents or carers), for example by helping the parent or carer to respond more sensitively to the child.

Bullying

Persistent behaviour by a person or group of people that intentionally hurts a child or young person either physically or emotionally.

Child sexual exploitation

Exploitative situations, contexts or relationships in which children or young people are given something (for example, food, drugs, gifts or money) in return for participating in sexual activities.

Child trafficking

Recruiting and transporting children and young people for the purposes of exploitation, for example, sexual exploitation, forced labour or services, domestic servitude or the removal of organs.

Children and young people

In this guideline 'infant' means aged under 1 year, 'child' means under 13 years and 'young person' means 13 to 17 years.

Disabled children

Children who meet the Equality Act 2010 definition of disability, namely those who have a physical or mental impairment that has a substantial and long-term negative effect on their ability to do normal daily activities.

Early help

Support provided early as soon as a problem emerges. Early help can prevent a problem from worsening or further problems from arising.

Emotional abuse

Persistently treating a child or young person in a way that can cause severe adverse effects on their emotional development. For example, conveying to them that they are worthless or unloved; not giving them opportunities to express their views; deliberately silencing them or making fun of them; imposing inappropriate expectations on them for their age or developmental stage; and serious bullying (including cyber bullying).

Faltering growth

This term is used in relation to infants and young children whose weight gain occurs more slowly than expected for their age and sex. In the past this was often described as a 'failure to thrive' but this is no longer the preferred term.

Female genital mutilation

A practice involving removal of or injury to any part of a girl's external genitalia for non-medical purposes. Female genital mutilation is illegal in England and Wales according to the Female Genital Mutilation 2003 Act.

Forced marriage

A marriage in which one or both partners have not consented (or cannot consent because of a learning disability) to be married and pressure or abuse has been used.

Foster carer

Foster carers care for children who are 'looked after' in the public care system. They provide care for the child as a member of their household and receive payment for this. Some are 'kinship foster carers', which means they are relatives or friends who are fostering a child who has entered the public care system.

Gillick competent

A child under 16 is said to be Gillick competent if they are judged to have sufficient intelligence and understanding to consent to, or refuse to consent to, medical treatment, which includes the prescription of contraception. Additional consent by a parent or person with parental responsibility is not required.

Indicators

Symptoms and signs that may indicate that abuse or neglect is taking place.

Maltreatment

In line with the NICE guideline on child maltreatment child maltreatment includes neglect; physical, sexual and emotional abuse; and fabricated or induced illness. It is also used as an 'umbrella' term for all categories of abuse and neglect, including witnessing domestic violence, forced marriage, child trafficking, female genital mutilation and child sexual exploitation.

Neglect

The persistent failure to meet a child or young person's basic physical or psychological needs, which is likely to impair their health and development. It may also include neglect of, or being unresponsive to, their basic emotional needs. Maternal substance abuse during pregnancy can also constitute neglect.

Parent or carer

This guideline uses 'parent or carer' to acknowledge that people other than a child's parent may be caring for them. We have defined 'parent' as the mother or father of a

child, and ‘carer’ as someone other than a parent who is caring for a child. This could include family members, such as the partner of a parent. Where we are referring specifically to paid carers we use the term ‘foster carer’.

Parenting intervention

An educational intervention focusing on improving parenting skills.

Past abuse and neglect

Abuse or neglect that a child or young person may have experienced but which is no longer occurring. For example, abuse which occurred in a previous family environment before the child or young person was placed in care or with an adoptive family.

Physical abuse

A form of abuse that involves physically harming a child or young person (for example, by hitting, shaking, throwing, poisoning or burning). Physical harm may also be caused if a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Practitioner

A professional working with children and young people who may have a role in safeguarding them.

Risk factor

Situations, behaviours or underlying characteristics of children and their parents or carers that increase the child’s vulnerability to abuse or neglect.

Sexual abuse

Sexual abuse means forcing or enticing a child or young person to take part in sexual activities. This includes physical contact but also non-contact activities, such as looking at or producing sexual images, watching sexual activities, encouraging them to behave in sexually inappropriate ways, or grooming them in preparation for abuse (including through the internet).

Special guardian

A person who has been granted a special guardianship order (SGO), a private law order which grants parental responsibility for a named child. While parents do not lose parental responsibility when an SGO is granted, the special guardian has the exclusive right to exercise it, and make important decisions about the child. Special guardians may also in some circumstances be provided with local authority financial and other support.

For other social care terms see the Think Local, Act Personal Care and Support Jargon Buster.

Abbreviations

Abbreviation	Term
CBT	Cognitive behavioural therapy
CI	Confidence interval
CSA	Child sexual abuse
CSE	Child sexual exploitation
CYP	Children and young people
FGM	Female genital mutilation
IPV	Intimate partner violence
LSCB	Local Safeguarding Children Board
MASH	Multi-agency safeguarding hubs
MST-CAN	Multi-systemic therapy (child abuse and neglect)
OR	Odds ratio
PSS	Personal social services
PTSD	Post-traumatic stress disorder
RCT	Randomised control trial
SCR	Serious case review

About this guideline

What does this guideline cover?

The Department of Health (DH) and the Department for Education (DfE) asked the National Institute for Health and Care Excellence (NICE) to produce this guideline on child abuse and neglect (see the scope).

The recommendations are based on the best available evidence. They were developed by the guideline committee – for membership see section 7.

For information on how NICE social care guidelines are developed, see Developing NICE guidelines: the manual

Other information

We will develop a pathway and information for the public and tools to help organisations put this guideline into practice. Details will be available on our website after the guideline has been issued.

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