

# Improving the effectiveness of the child protection system – A review of literature

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This research paper was produced as part of a wider project on improving the effectiveness of the child protection system, commissioned by the Early Intervention Foundation (EIF) in collaboration with the Local Government Association (LGA) and supported by the NSPCC, Research in Practice and the University of Oxford. The project had five strands, all of which are published as separate research papers. An overview report, published by EIF and the LGA, brings together the key findings, lessons and recommendations from this wider programme of research.

This paper and others in the series can be accessed via the EIF website, at <http://www.eif.org.uk/publication/improving-the-effectiveness-of-the-child-protection-system-overview>

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## Table of Contents

<b>TABLE OF CONTENTS</b>	2
<b>EXECUTIVE SUMMARY</b>	3
<b>1. BACKGROUND, AIMS AND OBJECTIVES</b>	25
<b>2. STUDY DESIGN</b>	25
<b>3. RESULTS</b>	31
3.1 Assessment and engagement	31
3.2 Motivation and retention of families in treatment	38
3.3 Practitioner role, management and training	45
3.4 Innovative models of practice	49
3.5 Effective programmes and interventions	54
3.6 Targeted Youth Services	70
3.7 Cost-benefit analysis	72
<b>4. CONCLUSION</b>	77
<b>5. CRITICAL APPRAISAL OF INCLUDED STUDIES</b>	78
<b>REFERENCES</b>	170

### TABLES

<b>Table 1:</b> Included Studies	29
<b>Table 2:</b> Assessment	78
<b>Table 3:</b> Motivation and engagement of parents in treatment	96
<b>Table 4:</b> Practitioner role, management and training	101
<b>Table 5:</b> Innovative models of practice	110
<b>Table 6:</b> Effective interventions with children on the edge of care	113
<b>Table 7:</b> Targeted youth services	166

## Executive Summary

### Introduction

The Improvement Board of The Local Government Association (LGA) commissioned this piece of work in order (i) to better understand the evidence on what works in child protection, and (ii) to consider how the evidence can be used locally to inform decisions on how best to manage demand on Children's Social Care services within the constraints of existing resources. This project has been undertaken as a joint-funded collaboration between the LGA, EIF and NSPCC.

### Aims and Objectives

The objective of this rapid review of the literature was to identify both known and emerging/innovative systems and practices that have been shown to improve outcomes for children (i) who have experienced abuse and neglect or (ii) are clearly identified as being at risk of abuse.

The objective of the review was also to identify effective programmes, as well as evidence regarding effective methods of assessment and engagement, and practitioner training, working and management.<sup>1</sup>

Where possible the analysis aimed to identify the reliability of the evidence; scale of impact; and evidence of potential to reduce costs or mitigate the need for increased spending on children's services and other parts of the child protection system.

### Methods

This paper is based on a rapid view of the best current evidence available on the following:

- Pre-proceedings
- S17 (CiN) including children who go missing
- S47 (Child Protection)
- Targeted support (e.g. troubled families)
- Risk of CSE / targeted youth support (which may indicate existence of abuse, neglect and other harms that are not being addressed through formal child protection processes)

The review does not include literature on specific forms of severe harm, including criminal offences such as trafficking or female genital mutilation (FGM), which require immediate implementation of child protection procedures. Neither does it include guidelines on general treatment of alcohol or substance misuse or severe mental health problems that can increase the risk of child abuse and neglect. Reference is provided to relevant NICE guidelines in the references.

### Data synthesis

A narrative summary of the findings has been produced, which includes summary text and tables detailing the key findings.

### Results

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<sup>1</sup> In this context, effectiveness is defined as achievement of the intervention's intended objectives: for example reduction or eradication of risk of further abuse to the child and amelioration/recovery from the consequences of abuse.

28 reviews are included (see Table 1, Included Studies). Of these 5 are reviews of reviews, 19 are systematic reviews and 4 are non-systematic reviews of the literature. Further individual longitudinal, multisite evaluations were included on expert advice, as the topic areas (e.g. pre-care proceedings, short term residential care for adolescents) had not been included in systematic reviews. Reference is made to individual empirical studies conducted in the UK that have not yet been included at review level and reference is made to forthcoming reviews, such as NICE guidelines on Child Abuse and Neglect, when these contain new evidence on areas of interest on which there is as yet relatively limited research. We have also referred to NICE evidence summaries where they are pertinent.

Included studies are organised as follows:

- Reviews of reviews
- Systematic reviews with meta-analyses
- Systematic reviews without meta-analysis
- Systematic review with narrative summary (i.e. no data)
- Non-systematic reviews
- Individual studies

*The above does not provide an indication of the rigour of the evidence, which was on the whole mixed, and readers are referred to the individual appraisal tables for an indication of the strengths and weaknesses of each included study.*

## Summary of Key Findings

### 1. Assessment of families, engagement and motivation

#### Sources:

- Systematic reviews without meta-analysis: Bailhache (2013), Ward (2012), Turney (2011).
- Systematic review with narrative summary (i.e. no data): Bartelink (2015);
- Non-systematic reviews: Thoburn (2009).

The need for thorough assessment is the foundation of the work that follows: although it does not guarantee success, good assessment greatly increases the likelihood of appropriate support within a reasonable time frame (Ward 2014).

## 1.1 Assessment

Note: Forthcoming guidance by NICE (2017) on Child Abuse and Neglect will contain recent evidence on assessment of maltreatment.<sup>2</sup>

### **Thresholds**

- One narrative review reported a wide variation in assessment thresholds in the UK, in particular in cases of neglect and/or emotional abuse, which it is suggested may be influenced in part by resource constraints at local level (Turney 2011).

### **Structured professional judgment and the assessment process**

- The use of “structured professional judgment” – the combination of professional knowledge and assessment tools. – is consistently recommended. This needs to be strengthened with access to emerging research and guidance (Bartelink, 2015; Barlow, 2006a, both reviews of reviews; Ward 2014; narrative systematic review).
- Training needs to involve the capacity to analyse data carefully. One non-systematic review (Thoburn, 2009) identifies factors that *hinder* analysis. These include:
  - i. cognitive errors (mistakes in interpreting information)
  - ii. fixed thinking (not challenging one’s own assumptions)
  - iii. practical demands, including pressure of work and the tight deadlines for the completion of assessment tasks
  - iv. emotional impacts of the work on the worker (for example, the effects of fear, violence and/or stress) and
  - v. the way that an organisation is structured and managed. Supervision is essential to promote good assessment, and to help workers in analysis and reflection

### **Assessing parents’ capacity to change**

- One review of the literature recommends drawing together a psychosocial history of the family at the outset in order to avoid repeating information gathering. This psychosocial history would require input from a range of sources and professionals (Thoburn, 2009).
- Case conceptualisation is recommended as a first step to assessment of parent’s capacity to change. This requires identifying strengths, weaknesses and threats within and beyond the family (Ward, 2014, narrative review).
- The use of a theoretical model of the different factors that promote or inhibit parental engagement can facilitate a greater understanding of the many interlocking issues that need

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<sup>2</sup> Draft review is available at: <https://www.nice.org.uk/guidance/indevelopment/gid-scwave0708>

to be addressed (Ward, 2014, narrative review). Transactional-ecological<sup>3</sup> and integrated models are recommended.<sup>4</sup>

- Once the case is clear, social worker and the parent(s) establish and agree goals and a time frame in which these goals are to be achieved is recommended (Ward, 2014, narrative review).

## 1.2 Assessment tools

This section summarises the key findings from a narrative review by Ward (2014).

Only a limited number of standardised tools are routinely used in a small number of local authorities in England.<sup>5</sup> As of mid-2014, the following were being used in the UK; of these, the best were found to be 70%-80% accurate in identifying risks of future harm, but most are much less reliable. Many assessment tools developed elsewhere require further validation in the UK before they can be reliably used.

- *Risk assessment tools*
- *Strengths and Needs Assessment tools*
- *Response Priority Decision Trees* - tools that are used to 'improve the consistency across workers and to prioritise decisions about initial reports of abuse and neglect, in order to focus the workload and aid decision-making.
- *Permanency/Placement and Reunification Checklists* focus explicitly on the likelihood of recurrence of harm in relation to decisions about permanency/placement and reunification.
- *Audit Tools*: similar to the risk assessment tools, but have been used to date as a means of auditing retrospectively whether cases have been classified accurately.

### ***Assessment of emotional abuse without co-occurring abuse***

- One review concluded that the identification, assessment and treatment of emotional abuse require a multidisciplinary approach because of the asymptomatic condition of some children, which means that problems may be difficult to identify (Barlow and Schrader-McMillan, 2010).<sup>6</sup>

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<sup>3</sup>Brandon, M. 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*. Research Report DCSF-RR023. University of East Anglia; Brandon, M. . et al (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07*. Research Report DCSF-RR129. University of East Anglia.

<sup>4</sup> Platt, D. (2012) 'Understanding parental engagement with child welfare services: an integrated model.' *Child & Family Social Work* 17, 2, 138-148.

<sup>5</sup> Checklists with no evidence base are often used in assessment in the UK.

<sup>6</sup> The FRAMEA framework developed has been developed by Glaser (2011) to identify the critical threshold in emotional abuse when this presents with no co-occurring form of maltreatment. Glaser D (2011) 'How to deal with emotional abuse and neglect – further development of a conceptual framework (FRAMEA)' *Child Abuse & Neglect* 35, 866-875. See also Barlow J and Schrader McMillan A (2008) *Emotional Abuse*. London: Jessica Kingsley.

### ***Child sexual abuse***

Although there are many published studies on forensic medical assessment of child sexual abuse (CSA) limited research was identified relating to *social work* assessment, or assessment of grooming, internet abuse, and other forms of CSA.

- One tool was found to have an accuracy of over 90% - the Structured Interview for Symptoms Associated with Sexual Abuse (SASA) (Bailhache, 2013).<sup>7</sup>

### ***Use of standard assessment tools with minority ethnic and other groups***

- Numerous weaknesses have been identified in relation to the assessment of children with disabilities and child asylum seekers (Turney 2011).
- Language barriers and lack of understanding of cultural practices that can either protect or harm children were identified as challenges in work with families of minority ethnic groups (Turney 2011).

### ***Training on risk assessment tools***

- Practitioners need (i) training on when and how to use assessment tools; and (ii) the limitations of various measures – as noted above; and (iii) topics such as resilience, self-esteem, attachment, and the identification of behavioural problems that can contribute to poor placement outcomes for looked-after children (Turney 2011).
- Front-line professionals (including, for example, GPs and community nurses) should be trained on communication skills that can facilitate conversations with children of different ages, adolescents, and parents (Ward, 2014).

## **1.3 Engaging the family in assessment**

(See also section 2, below)

Note: a forthcoming NICE (2017) guidelines on Child Abuse and Neglect will contain evidence on assessment, engagement and communication with children who have been exposed to any form of abuse or neglect.<sup>8</sup>

### ***Engagement of children***

The following are the key findings from one narrative review (Turney, 2011).

- Keeping the child 'in view' is fundamental to good assessment; there appear to be variable levels of practice in the UK.
- Barriers to engagement of children identified include: time constraints; limited or no knowledge on how to engage children; lack of confidence in the conduct of direct work or in undertaking child observations; insufficient support; blockages by adults in the family.
- Children may be very anxious about the consequences for their parents of talking about abuse or neglect.

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<sup>7</sup> Wells R, McCann J, Adams J, Voris J, Dahl B (1997) A validation study of the structured interview of symptoms associated with sexual abuse (SASA) using three samples of sexually abused, allegedly abused, and nonabused boys. *Child Abuse Negl* 21(12):1159–1167.

<sup>8</sup> Drafts are available at the time of writing on: <https://www.nice.org.uk/guidance/indevelopment/gid-scwave0708>

- Strategies that can enable engagement with children and young people include (i) taking time to build relationships, (ii) listening to young people and treating them with respect, (iii) giving information, (iv) providing support for them to understand records or reports, and (v) offering children real choices whenever possible.

### ***Factors that enable or hinder assessment***

The following were identified as part of a narrative review (Turney, 2011).

Barriers to quality assessment can emerge at several levels:

- personal barriers - related to a workers sense of competence, confidence and work load;
- interpersonal barriers - particularly around communication with families and other professionals; systems issues, including procedures and use of IT;
- organizational barriers - including inadequate resources and poor management.

Factors that enable quality in assessment were identified as:

- workforce knowledge, skills and confidence;
- support and supervision;
- adequate resources;
- workable and efficient systems of managing and recording information;
- good interpersonal relationships;
- IT and other systems to record and manage information that are not complex and time consuming
- regular 'organizational health checks' or audits about the quality of assessments

### **1.4 Motivation and retention of parents in treatment**

Unless otherwise specified, the primary source for this section is one systematic review with narrative summary (Ward, 2014).

- There is no guarantee that parents' engagement with services will lead to adequate, timely change across all domains.
- Parents facing multiple problems may become motivated to change in one area, but may not necessarily appreciate the need for change in others.
- Professionals need to be aware of the way that parents' own experiences of attachment can affect not only their relationships but also their engagement with services.
- Parents with poor communication skills may give the impression of being resistant, although they are in fact willing to engage. Equally, willingness to engage in treatment can be interpreted as willingness to change.
- Practitioners need to be alert to false compliance.
- Practitioners need notice when their own actions or role are creating resistance.

### ***Factors and strategies that help motivate people to change***

- Clarifying the perceived advantages and disadvantages of change may help both practitioners and parents understand why change is so difficult, and how it might be facilitated.

- Turning points in people's lives can provide opportunities to encourage and support change.
- Statutory interventions can become the cue to action for parents - but parents who are uncertain about their capacity to become can react by becoming more deeply entrenched in adverse behaviours.
- Informal pressure from friends and relatives can play a constructive role in motivating parents to change when combined with a package of timely, co-ordinated interventions from a range of professionals and the courts.
- One systematic review (Marsh 2012) found some evidence that statutory interventions *delivered in the home* can favour the client-provider relationship and treatment outcomes.
- There is extensive evidence to support Motivational Interviewing (MI) to encourage change across a range of problem areas, but there are wide differences in its effectiveness even in relation to the same issue. This suggests that the way in which MI is delivered can have a substantial impact on outcomes. Although research on the application of Motivational Interviewing (MI) in the context of domestic violence is limited, overall the evidence suggests that MI may be promising approach to integrate in treatment (BCCEWH, 2013).
- The application of MI to child social work requires a constant focus on the child's welfare and safety.
- The clearest message to emerge from included studies is the importance of a dedicated, well qualified, key worker who works closely, and in partnership with, the family for as long as is necessary, providing continuity and therapeutic, as well as practical, support.

### ***Preventing relapse by parents***

Unless otherwise specified, the primary source for this sections a systematic review with narrative summary (Ward, 2014).

- A key factor in the recovery and change process is the establishment of "virtuous circles" in which success in one area leads to success in others.
- Parenthood is a key motivator in sustaining change; interventions designed to increase parenting skills can also help reduce other problems that parents have by improving their self-esteem and sense of self-efficacy. However, there is great variation in the effectiveness of parenting programmes with different populations. If parents are inadequately supported, the stress of assuming their responsibilities can undermine progress – for example, in abstinence from harmful behaviours.
- The ability of parents to sustain change in the long term may be affected by the type and number of difficulties they are trying to overcome, and whether difficulties can be fundamentally resolved or only controlled and alleviated.
- Internal factors supporting the maintenance of change include feelings of self-efficacy and having what is perceived to be a 'normal' role in society (contributing, working, etc.). External factors include positive support networks and appropriate support from professionals.

- Internal factors that *undermine* the maintenance of change include: stress, mental health problems and co-existence of multiple difficulties. Social and demographic factors that *undermine* maintenance of change include poverty and social isolation, although social isolation may be an effect as well as a cause of stress for parents.
- Recovery from serious problems such as substance dependence is usually a gradual process extending over a period of years rather than a time-limited event. However, relapse can have a negative impact on children’s wellbeing because of the immediate and long-term impact of instability and exposure to harm.
- Change or recovery in one area of life does not automatically result in improvements in other areas. Therefore ongoing assessments should consider whether change can be achieved within the child’s time frame after taking into account the child’s needs, the nature of parents’ problems, factors which increase or decrease the likelihood of relapse, and availability of future support.

## 1.5 Shared decision-making

Unless otherwise specified, this section draws from a systematic review of reviews with a narrative summary (Bartelink, 2015), one reviews of the literature by Frost (2014b) complemented by additional material from an individual scoping study (Dixon, 2015).<sup>9</sup> Shared decision-making may improve the participation of parents and children and the quality of decisions by taking client treatment preferences into account in addition to scientific evidence and clinical experience. However, practitioners need to monitor child safety carefully.

- **The Family Partnership Model (FP)** <sup>10</sup> The FP has a robust theoretical foundation but no evidence was identified of improved outcomes in terms of child abuse and neglect.
- **Family Group Conferences (FGC)** Limited research to date shows that FGCs were valued by participating families and children and may provide a space in which families can interact in a safe and productive way, but there is no evidence as yet of improved outcomes for children, for example, in terms of reduced maltreatment. <sup>11</sup>
- **Family Group Decision-Making (FGDM)** offer potential methods of engaging parents who are ambivalent about change, mistrustful of social workers, or not fully ready for change. However, the evidence to underpin FDGM is not strong (see also Dixon, 2015). While this method of working has potential as a tool for family engagement (and is underpinned by a strong theory of change) there is as yet no evidence that it reduces child maltreatment recurrence or out-of-home placement, and may even have a negative effect on child safety. Bartelink *et al.* (2015) conclude that *combining* shared decision-making with close monitoring of child safety (using a method such as “Signs of Safety”, below) may be more appropriate for child maltreatment cases than family group decision-making alone.

<sup>9</sup> Frost, N. *et al.* (2014a), Family group conferences: evidence, outcomes and future research. *Child & Family Social Work*, 19: 501–50. See also: Frost, N. *et al.* (2014b), *Family group conferences: context, process and ways forward* *Child & Family Social Work*, 480–490;

<sup>10</sup> See: Davis, H. and Day, C. (2010). *Working in Partnership: The Family Partnership Model*. London: Pearson

<sup>11</sup> A forthcoming study on FGCs in South Leeds is due to be published by the University of Sheffield at the time of writing.

- **“Signs of Safety”** is a solution-focused approach for maltreating families. Although initial studies have reported positive outcomes in terms of client satisfaction, child maltreatment recurrence and out-of-home placement,<sup>12</sup> no peer-reviewed studies have yet been published although an evaluation in the UK is underway.<sup>13</sup> Promising initial reports justify further exploration.
- Motivational and solution-focused interviewing techniques may be useful as part of a shared decision-making process.

## 2. Practitioner role, management, and training

This section examines evidence about the way that the worker’s relationship-building skills and their capacity to manage difficult situations can contribute to treatment outcomes.

### Sources:

- Systematic reviews with meta-analysis: Al (2012); Niccols (2012); Macdonald (2012)
- Systematic reviews without meta-analysis: Marsh (2012), Turney (2015)
- Reviews with narrative summary: Ward (2014)
- Non-systematic reviews: Macmillan (2009); McFadden (2015)

### 2.1 Client provider relationship and treatment outcomes

The following section summarises key messages from one systematic review without meta-analysis (Marsh, 2012), with additional findings from a review with a narrative summary only (Ward, 2014).

- Qualitative evidence shows consistently that the relationship between parent(s) and worker can predict the process (i.e. the degree to which parents participate and whether they remain in treatment) but it is less accurate in predicting outcomes.
- Changes of social worker can be detrimental to successful case management because they obstruct the development of constructive, supportive relationships with parents and children, and the implementation of plans. Such changes reflect the widespread use of agency staff, the high turnover of more permanent staff, and the organisation of services, which often require cases to be transferred from one team to another as families move through the system. Comparative and longitudinal studies suggest that social work on child protection is most effective when:

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<sup>12</sup> Turnell, A. (2008). *Adoption of Signs of Safety as the department for child protection’s child protection practice framework*. Perth: Government of Western Australia (Department for Child Protection); Turnell, A., & Essex, S. (2006). *Working with ‘denied’ child abuse. The resolutions approach*. Maidenhead: Open University Press.

<sup>13</sup> Further research is currently underway by the NSPCC in the UK: <https://www.nspcc.org.uk/globalassets/documents/research-reports/signs-safety-england.pdf> and in Australia by the Australian Centre for Child Protection (ACCP) at the University of South Australia. See: <http://www.signsofsafety.net/research/>

- Thorough and timely assessments lead to the identification of clearly specified goals and targets concerning what needs to be changed and provide parents with the support they need to achieve change without delays;
  - Both social work and specialist services are combined to support such changes;
  - Interventions include careful planning with children and families;
  - There is strong, proactive case management;
  - There are no changes of social worker unless the family is dissatisfied;
  - A strengths-based approach that acknowledges the challenges parents is likely to be more effective than overly focusing on parental deficits that is more likely to lead to resistance.
- Research with families show that they value child and family social workers (i) who are straightforward and honest about what needs to change and the likely consequences of not doing so; (ii) show sensitivity; (iii) listen to and try to understand parents circumstances; (iv) exercise professional power to help provide practical support, e.g. in relation to parents' housing problems; not using their power over parents: (v) work from a strengths perspective.
  - Studies of serious case reviews reported in the same paper also draw attention to the characteristics of *ineffective* relationships between social workers and parents; this includes: (i) unrealistic expectations of parents' capacity to change; (ii) cultural relativism - beliefs about one's own, or other people's, culture that condones abuse or neglect; (iii) not being able to manage parents' overt hostility towards the worker.
  - Social work interventions are often relatively short-term because of the pressure to close cases (and save resources); this is particularly harmful when inadequate arrangements are in place for long-term, less intensive support or monitoring of children's circumstances.

## 2.2 Factors affecting staff retention

The following summarises key findings from a non-systematic review (McFadden, 2015).

- Staff are more likely to burn out, and to leave, because of organisational issues, such as lack of adequate supervision and peer support, than because of the inherently challenging nature of the work. Staff retention and low turnover are associated with constructive organisational cultures, supportive social and supervisory support, and manageable workloads.<sup>14</sup>
- Personal experience of abuse and neglect can impact on practitioners in social care. This risk can be reduced by learning coping strategies as part of professional and in-service training and by supportive management.

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<sup>14</sup> Assuming of course, that there are other job opportunities for dissatisfied staff.

### 2.3 Training, learning and development

The following summarises key findings in a non-systematic review (McFadden, 2015).

#### *Social work qualifying courses*

- Professional and in-service training needs to include practical skills on managing stress and developing resilience. Resilience increases with the application of active, positive coping styles and by personal development, including regular good-quality primary and ongoing training that includes booster sessions.
- In-service training should include regular opportunities to update knowledge on research and evidence around child development and work with families.
- Child (and especially adolescent) development is still not covered thoroughly or consistently in social work qualifying courses.

#### *In service training*

The following recommendations are made in a systematic review by Turner (2015).

- There is some evidence in that improvements in perceived competence can be translated into measurable changes in clinical practice (documented by clinical record audits). However, this is not necessarily sustained consistently over time. This points to the need for reinforcement (e.g. booster sessions).
- In-service training on child and adolescent development is particularly recommended.
- Practitioners' capacity to apply knowledge to everyday work is enabled in organisational climate that encourages and accommodates learning, and which includes on-the-job supervision and support. As noted above, organisational climate is associated with staff retention or turnover as well – and is therefore of critical importance.

### 3. Innovative Models of Practice

The general case management and family support provided by social workers has not been formally evaluated in England. Although there are promising innovations there is limited evidence about their effectiveness and this often has to be pieced together from studies where the subject was peripheral to the main focus of the research. A number of innovative service models and practice methodologies have been proposed in order to provide a more risk sensitive and timely response, and to reduce further likelihood of error. A very small number of studies suggest that innovative models are more likely to be found where adult substance misuse intersects with child safeguarding.

The remit, accountability and scope of Local Safeguarding Children's Boards (LSCBs) have been the subject of a recent government-commissioned review.<sup>15</sup> The government will be developing a new

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<sup>15</sup> Wood, A. (2016) *Review into the Role and Functions of Local Safeguarding Boards*. London: Department for Education. See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/526329/Alan\\_Wood\\_review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf) (Accessed 12/01/17); Department for Education (2016) *Review into the Role and Functions of Local Safeguarding Boards. The Government's response to Alan Wood CBE*. London: Department for Education. See:

statutory framework that will strengthen the mandate of local LSCBs while enabling local partners the freedom to decide how they operate to improve outcomes for children within agreed standards. However, there is as yet limited evidence in relation to any models of practice in the UK, particularly in terms of child and family outcomes.

**Source:**

This section draws on two reviews and one additional individual paper:

- A systematic review reported in narrative form: Luckock, 2015).
- Non-systematic review of the literature: Thoburn, 2009). <sup>16</sup>This section also includes some key findings on pre-care proceedings from an individual study by Masson (2013).<sup>17</sup>

### 3.1 Models of multiagency work in the UK (as of 2014)

The following methods of multiagency work (involving different sectors) were identified in one systematic review (Luckock, 2015):

- Screening for maltreatment within routine/universal services;
- Common assessment;
- Multi-agency team working: includes 'virtual' and 'co-located' teams, in some cases led from within 'adult social care' services.

The review highlights the importance of communication and quality of dialogue among stakeholders in the safeguarding process. Clear, consistent and open communication is a common factor to enabling children, parents and professionals to recognise and respond to areas of concern in a way that is acceptable to all and that can lead to effective change. The lead professional needs to ensure that relationships between children and parents are developed in such a way that dialogue can be sustained.

### 3.2 Other possible models that require evaluation

- A co-working model, with two workers sharing the lead professional role for the family as a whole, is an innovative approach developed from family therapy.

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[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/526330/Government\\_response\\_to\\_Alan\\_Wood\\_review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526330/Government_response_to_Alan_Wood_review.pdf) (Accessed 12/01/17)

<sup>16</sup> Masson J. *et al.* (2013) *The pre-proceedings process for families on the edge of care proceedings*. (See: <http://www.bristol.ac.uk/media-library/sites/law/migrated/documents/summary.pdf>. Accessed 28/04/16).

<sup>17</sup> Masson J. *et al.* (2013) *The pre-proceedings process for families on the edge of care proceedings*. (See: <http://www.bristol.ac.uk/media-library/sites/law/migrated/documents/summary.pdf>. Accessed 28/04/16).

- A single worker with a very small case load and 24-hour availability of supervision/consultation, as in the intensive family preservation models developed in the USA and adapted in some agencies in the UK.
- Particular care is needed when working in a team around a child as this can lead to collusion with one or other parent and a loss of focus on the child.
- Continuity of social support is essential for families with complex problems, where change is hard to achieve, or hard to maintain. For this reason, as well as in order to provide for more continuity in professional networks, there has been a move towards a community-based model of case allocation. However, increasing availability of social support to especially vulnerable families should supplement, not substitute, the social casework service.

### 3.3 Pre-care proceedings

A single longitudinal multisite evaluation of pre-care proceedings was identified (Masson 2013).<sup>18</sup>

- This found that pre-care proceedings are valued by social workers, their managers, and parents. When there is enough time to use them, pre-care proceedings can enable enough change in a family for a proportion of children to remain with their parent(s). However, the process did appear to delay decisions for children who did have to enter care.

### 4. Effective programmes and interventions with children and families at the edge of care<sup>19</sup>

Where families are facing complex, multi-layered problems, an integrated package of support is almost certainly required. The components of this package must be identified following assessment. This can include some of the parenting programmes outlined in this section, which focuses on evidence regarding programmes designed for families with more severe difficulties.

The following is an outline of programmes that can form part of a time-limited, integrated package of support, for families in which a child is on the edge of care. The literature on interventions is on the whole well developed, and this section draws on multiple reviews, although there are significant gaps, particularly around neglect, and there are very few studies that report specifically on work with fathers of children who have been abused and/or are on the edge of care.

- In order to provide access to further information about each topic, links to external web pages have been provided in the main paper. The detail and quality of information differs according to what is currently available online and readers may wish to explore additional sources.

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<sup>18</sup> Masson, Ibid.

<sup>19</sup> These findings will be enhanced by forthcoming NICE guidelines on Child Abuse and Neglect, due to be published in September 2017. Where there are new findings, reference is made in this section to emerging recommendations from the draft version, which is currently under review. This also provides detailed guidance on work with any child or young person who has been abused and/or neglected or exploited

**Sources:**

- Review of reviews: NICE (2015); BCCEWH (2013); Barlow (2006a)
- Systematic reviews with meta-analysis: Al (2012); Niccols (2012); Macdonald (2012)
- Systematic reviews and/or reviews of reviews without meta-analysis: Barlow and Schrader-McMillan (2008); Smith (2012); Woods (2011); Barlow (2006b); Turney (2011); Barlow (2016)
- Reviews with narrative summary: Montgomery (2009); Oliver (2009); Ward (2014).
- Non-systematic review: Macmillan (2009)
- Individual scoping study: Dixon (2015)

#### 4.1 Individual programmes

##### i. Promoting child attachment security in maltreated children

The following recommendations are from the findings of a NICE (2015) systematic review with meta-analysis and from a systematic review/review of reviews summarised by Barlow (2016). Most research on strengthening parental sensitivity and child attachment security focuses on children under the age of five. There has been limited empirical research on promoting attachment security in children aged 6 and beyond.

The evidence supports interventions that are relatively short and have a behavioural (i.e. sensitivity) focus. In particular, interventions involving video feedback may improve sensitivity/responsiveness and secure attachment, and reduce insecure attachment in high risk groups of children. One included RCT that involved children who had been maltreated shows that Video Interaction Guidance (VIG) can increase child attachment security and maternal sensitivity after maltreatment has occurred.<sup>20</sup>

One RCT provides support for the Minding the Baby, a mentalisation based home visiting programme for young mothers in high risk groups, including those who present child protection concerns. A further trial is underway in the UK with support of the NSPCC.

There is evidence based on a number of RCTs to support Parent-Infant Psychotherapy (PIP) in terms of improved improving infant attachment in high-risk families. Further research is needed into its impact on potentially important mediating factors, such as mental health, reflective functioning and parent-infant interaction, and its effectiveness relative to other methods of working.

##### ii. Cessation of physical abuse

This section draws on five papers: one a review of reviews (Barlow 2006a), a systematic review without meta-analysis (Barlow 2006b) and three systematic reviews with a narrative summary only (Macmillan 2009; Oliver 2009; Ward, 2014). There are several problems in assessing the effectiveness of interventions with families where a child has been physically abused because few include objective measures (e.g. police reports, hospital visits, etc).

- The most consistent evidence supports Parent Child Interaction Therapy (PCIT) in improving some outcomes associated with physically abusive parenting.<sup>21</sup> PCIT is an individualised intervention developed for parents and children with behavioural problems aged 4-7 years which involves parents and children in conjoint sessions that include direct coaching and practice of skills (Barlow 2006a; Barlow 2006b; Macmillan 2009; Oliver 2009; Ward, 2014; Barlow 2006b).
- Other potentially helpful family-focused interventions include family-focused casework and therapeutic groups (e.g. Florida Infant Mental Health Pilot Programme, and Parent Child Attunement Therapy (PCAT) (Barlow 2006a).
- There is evidence to support multi-systemic family therapy (MSFT) as a component of treatment for physical abuse (Barlow 2006a). However the impact of MSFT programme may depend on the severity and complexity of the families' problems (Oliver 2009).
- There is evidence based on one robust longitudinal study to support the Childhaven therapeutic day-care programme *for preschool children who have been physically abused*<sup>22</sup> (Montgomery 2009). This study showed that significant effects on parenting and child behaviour (including aggression and delinquency) were maintained over 12 years after completion of the programme.
- Two reviews found evidence to support solutions-focused brief therapy (SFBT) for child externalising and internalising behaviours which may be linked to abuse, although further research is needed with children who have been demonstrably maltreated (Woods, 2011; Montgomery 2009).
- There is no evidence that standard parenting programmes designed for universal or even demographically higher risk groups are effective with families where children are on the edge of care. However, staged programmes like Triple P can be used as a filter in which families with more complex needs are identified (Barlow 2006b; Ward 2015).
- There is some evidence that standard programmes with additional components designed to address problems associated with abusive parenting (e.g. excessive anger, misattributions, and poor parent-child interaction) are more effective than standard parenting programmes alone (Barlow, 2006a; Oliver, 2009; Macmillan 2009).

### iii. Sexual abuse

One systematic review (Macdonald 2012) recommends trauma-focussed cognitive-behavioural approaches as part of a flexible, staged response. Other forms of cognitive-behavioural therapy can improve specific mental-health outcomes for sexually abused children with post-traumatic stress symptoms, including post-traumatic stress disorder, anxiety, and depression. There is some evidence of modest effects on aspects of parenting.

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<sup>21</sup> See for example: Chaffin M et al. (2004) Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports. *J Consult Clin Psychol* 72: 500-10.

<sup>22</sup> Moore, E., Armsden, G. & Gogerty, P. L. (1998) A twelve-year follow-up study of maltreated and at-risk children who received early therapeutic child care. *Child Maltreatment*, 3, 3-16.

**Note:** forthcoming guidelines on child abuse and neglect by NICE (due in September 2017) advise the following:

- Sexual abuse: for boys and girls For boys and girls aged 8 to 17 who have been sexually abused, consider a programme such as 'Letting The Future In (LTFI).'<sup>23</sup>
- For girls aged 6 to 14 who have been sexually abused and who are showing symptoms of emotional or behavioural disturbance, the recommendation is careful discussion with the girl about her own preference, for either individual focused psychoanalytic therapy or group psychotherapeutic and psychoeducational sessions. Separate sessions need to be provided for the non-offending parent or carer.

#### **iv. Emotional abuse<sup>24</sup>**

The following section summarises key findings from a systematic review without meta-analysis of treatment of emotional abuse that does not involve any other form of maltreatment (Barlow and Schrader-McMillan 2010). It also draws on Ward (2014) and Nicholls (2012).

##### *Parent-focused interventions:*

- There is some evidence based on a very small number of weak studies that behavioural social work has potential to improve the negatively charged interactions between parents and young children that for example, result in feeding difficulties and infant failure-to-thrive.

##### *Parent- and child-focused interventions:*

- There is evidence to support Watch, Wait and Wonder; Pre-school parent psychotherapy (PPP); and the Parent Child Game (PCG) in families where the difficulties are severe and/or longstanding.
- Video Interaction Guidance (VIG) can help change frightening/frightened behaviour in parents and (as noted above) strengthen attachment and parent-infant interaction, often within a short number of highly focused sessions.

#### **v. Children exposed to parents with impaired personality functioning**

- There is good evidence that some elements of impaired personality functioning can be treated with long-term intensive therapy (Ward, 2014). Evidence-based programmes include mentalization-based treatment, dialectical behavioural therapy and schema-focussed therapy.

#### **vi. Children exposed to parents who abuse drugs and/or alcohol**

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<sup>23</sup> For evidence on LTFI, see: Carpenter J *et al.* (2016) *Letting the Future In: A therapeutic intervention for children affected by sexual abuse and their carers. An evaluation of impact and evaluation.* London: NSPCC.

<https://www.nspcc.org.uk/globalassets/documents/research-reports/letting-the-future-in-evaluation.pdf>

<sup>24</sup> Definitions of emotional abuse include missocialisation, e.g. exposure to parental drug and alcohol abuse and exposure to domestic violence. See other relevant sections in this paper. See also section on strengthening child attachment security, above, and relevant NICE guidelines in references section.

- Programmes that combine a focus on substance-use and parenting can be effective in improving outcomes for children (Niccols, 2012).
- For example, there is evidence from one high quality study to support the Parents under Pressure (PUP) programme for high risk families where a parent is receiving methadone treatment.<sup>25</sup>
- Emerging, recent evidence from a five year longitudinal study (Harwin, 2016), shows promising results for the Family Drug and Alcohol Court programmes.<sup>26</sup> This finds significant gains in the intervention group with respect to: mothers being reunited with children at the end of proceedings; absence of significant disruption (a combination of relapse, permanent placement change or return to court) over a 3 year period after proceedings ended; cessation of substance use at the end of proceedings and in the five years following the intervention. The size of sample was small and further studies are needed.

## vii. Domestic violence

Unless otherwise specified, this section draws primarily from NICE guidelines (BCCCWH, 2013)

### **a. Work with victim-survivors of domestic violence (DV)**

There is moderate evidence to support the following forms of support for victim-survivors of abuse:

- Advocacy services;
- Skill building;
- Counselling interventions aimed at improving PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, re-occurrence of violence, birth outcomes for pregnant women, motivational level and/or readiness to change. While most interventions reported improvements on the various outcomes measured, some reported only modest improvements or improvements on some, but not all, measures;
- Intensive therapy interventions such as group therapy may be effective for improving various PTSD symptoms, depression, trauma symptoms, psychological and social outcomes, parenting/ family-related outcomes and in some cases may reduce likelihood of future IPV or re-abuse;
- Restraining orders against abusive partners may prevent recurrent abuse.

### **b. Work with perpetrators of DV**

Aspects of personality functioning associated with increased risk of violence perpetration include difficulties in interpreting emotionally charged situations, managing strong emotions and impaired capacity for mentalization (the capacity to interpret what others are actually thinking

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<sup>25</sup> An RCT of PUP has been commissioned by the NSPCC and is being currently evaluated by the University of Warwick . See: <https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/parents-under-pressure/parents-under-pressure-evidence-impact-and-evaluation-evidence-impact/>

<sup>26</sup> Harwin, J. *et al.* (2016) *After FDAC: outcomes 5 years later: A continuation study of the first Family Drug and Alcohol Court (FDAC) in care proceedings.* University of Lancaster. (See: <http://fdac.org.uk/wp-content/uploads/2016/09/FDAC-Report-final-1.pdf> Accessed 18/01/17).

and feeling based on their expressions and behaviour). The references section of this report includes relevant NICE guidelines – for example, on treatment of borderline personality disorder.

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#### *Batterer Intervention Programmes (BIPs) and Cognitive-Behavioural Therapy (CBT)*

- Review level evidence on Batterer Intervention Programmes (BIPs) based on psychoeducational/Duluth models has consistently shown low effect sizes in terms of perpetrator behaviour change. Effects are stronger on changes in beliefs and attitudes associated with violence than on recidivism.<sup>28</sup> One exception to this is the Mirabal project, a five year longitudinal study undertaken in the UK, on Domestic Violence Perpetrator Programmes (DVPPs). Positive findings were reported for women's perceived sense of safety (i.e. reduction of exposure to violence), with varying trends in the desired direction on other outcomes. However, no difference was found between the intervention and control group and control group data was excluded from the final report, a methodological weakness that limits the strength of this study.
- An evaluation of a fathering programme for partner-violent men - Caring Dads, Safer Children (CDSC) - found evidence of sustained change among a proportion of fathers who completed the programme, although even among some fathers who completed the programme change was insufficient to cease monitoring contact with their families.<sup>29</sup>
- Evidence on cognitive behavioural therapy (CBT) for perpetrators of domestic abuse also tends to show limited effects in changing perpetrator behaviour. This appears to be equally true of shorter (under 6 months) and longer-term programmes.

#### *Motivation to change*

- Although there has been limited research on the application of Motivational Interviewing (MI) in the context of domestic violence, this suggests that MI may be promising approach to integrate in treatment.

#### *Couples therapy with and without treatment for substance abuse*

- There is some, poor quality evidence to support behavioural couples therapy that does *not* include treatment of substance abuse, in terms of reduction of aggression outcomes and improvements in relationship skills, satisfaction and conflict. Effect sizes are modest.
- There is moderate evidence that behavioural couples therapy (BCT) included within substance-use treatment is associated with improved abuse outcomes. Some studies find evidence of reduction in parent's substance abuse.

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<sup>27</sup> The References list also contains NICE guidelines on mental health issues (such as borderline personality disorder and addiction), which compound risk of DV perpetration.

<sup>28</sup> Kelly L and Westmarland N (2015) *Report on Project Mirabal*. Durham University and University of West London. Available online: <https://www.dur.ac.uk/resources/criva/ProjectMirabalfinalreport.pdf> (Accessed 12/11/16).

<sup>29</sup> McConnell et al, (2016) *Caring Dads: Safer Children: Learning from delivering the programme*. London: NSPCC.

### ***c. Children exposed to DV***

Unless otherwise specified, this section draws primarily from the review of reviews by BCCEWH (2013). This found that the most effective interventions for children involve both nonoffending parent and child in treatment.

#### *'Stand-alone' therapeutic and psychoeducational interventions:*<sup>30</sup>

- Moderate to strong evidence that therapeutic interventions aimed at both mother and child are effective in improving child behaviour, mother-child attachment and stress and trauma-related symptoms in mothers and children. Intervention approaches included: mother-child psychotherapy, shelter-based parenting intervention combined with play sessions for children, parent-child interaction therapy (including mother-child play, teaching of praise and discipline techniques), and an experiential, activity-based and interactive therapy intervention.
- Moderate evidence that psycho-educational interventions (addressing skills such as: stress and conflict management, coping and relationship skills, understandings of violence, etc.) are effective in improving children's coping skills, behaviour, emotional regulation, conflict resolution skills and knowledge about violence.

#### *Multicomponent interventions*

- Moderate evidence that multicomponent interventions with a focus on advocacy are effective in reducing trauma symptoms and stress in both children and families, and in improving child behaviours such as aggression. Interventions included: community-based service planning, nurse case management, and non-parental childcare for disadvantaged families. These studies were also of moderate quality.

### **viii. Neglect**

- There is some evidence from small studies that school based resilience-peer training, certain forms of imaginative play training (play therapy) and therapeutic day training may improve emotional and behavioural outcomes in children who have experienced chronic neglect (non-systematic review by Macmillan, 2009). Although these interventions can have positive effect they do not in themselves target the root of the problem, which is often parental and family dysfunction. They are therefore recommended as part of a continuum of interventions.
- There is also some evidence to support multisystemic therapy to improve the quality of parent child interaction where children have experienced neglect.

### **ix. Interventions that focus on fathers**

- One systematic review by Smith (2012) focused on the effectiveness of prevention programmes for child maltreatment that included fathers. Two studies of interventions that provided data that is specific to fathers were identified. Results support the Dads Actively Developing Families programme ('DADs') programme for men in prison as effective in attitudes and behaviours.
- Mixed evidence was found of a second intervention, a targeted home visiting programme. This found no significant impact on parenting of fathers who were violent at baseline but benefits for fathers who were not violent.

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<sup>30</sup> These are described as 'single-component' interventions in the original report.

- Positive effects were reported for other included programmes, designed to involve both fathers and mothers, but as results for men and women are not reported separately it is difficult to know what works best specifically for fathers. The study draws attention to barriers to fathers' engagement with programmes – for example, the time at which a service is offered – which affect father's participation. This points to the need for further research.
- x. Intensive Family Preservation programmes for families in crisis**
- Intensive family preservation programmes have been robustly evaluated in the US and on a smaller scale in the UK, where the 'Option 2' project has been designed along similar lines to the Homebuilders programme in the UK.<sup>31</sup> Evidence shows with some consistency that IFPS are effective in providing respite/improving family functioning when a child is on the edge of care because of a temporary crisis but that the intervention is less effective with families in which there has been a pattern of chronic child abuse and neglect (Al 2012).
  - Intensive family preservation services for families in a temporary crisis may be more effective (i) if they are preceded and/or followed by targeted lower-intensity or episodic services, or (ii) if families can re-enter the service of their own will if stress levels rise again (Ibid).
- xi. Older maltreated children with trauma symptoms**
- Parent-child psychotherapy or trauma-focused cognitive therapy may improve parental sensitivity or attachment security in children and young people who have been maltreated with trauma symptoms (Macmillan, 2009).
  - NICE (2015) recommends the following standard evidence-based treatments for trauma including: for older children who have been maltreated and/or show attachment insecurity and signs of trauma: (i) cognitive behavioural therapy (CBT), (ii) interpersonal therapy, (iii) eye movement desensitisation and reprocessing, (iv) dialectical behaviour therapy, (v) cognitive analytic therapy and (vi) family therapy.
- xii. Short-stay residential care for adolescents on the edge of care**
- The following is a summary of findings in a scoping study by Dixon (2015).
- Short-stay residential care that combines direct work with young people *and* support for their families can better meet the needs of *some* older adolescents and/or those with more challenging behaviours than foster or kinship care.
  - There is some evidence that short-stay residential care (i) can help reduce entry to care by improving young people's relationships with their families, and their families' ability to care for them; (ii) support planned and appropriate entry to care for those young people who cannot stay with their families; and (iii) reduce costs.
  - The following conditions were identified as contributing to successful in terms of sustained family reunification: (i) the need for very careful assessment; (ii) good staff training; regular risk assessments; (iii) appropriate matching of young people in the home, under regular

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<sup>31</sup> See: Forrester, D. *et al* (2012) *Final Report on the Evaluation of "Option 2"*, Welsh Assembly Government. Available online: [http://alcoholresearchuk.org/downloads/finalReports/FinalReport\\_0095.pdf](http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0095.pdf)

review; (iv) tailored, needs led packages of support; (v) effective multi-agency working with firm agreements in place; agreements made with families and young people.<sup>32</sup>

- However, there are also risks associated with the model, including (i) pressure on staff, the possibility of young people negatively affecting each other, and (ii) the risk that care-preventative approaches might prove ineffective or indeed be detrimental if they delay entry to care.

### **xiii. Other approaches to strengthen family functioning – families on the edge of care**

The following is a summary of findings in a scoping study by Dixon (2015).

- There is evidence, primarily from the US, to support multi-systemic family therapy (MSFT) in improving family relationships and reducing both the short- and long-term rates of re-offending amongst serious young offenders. It suggests that the impact of the programme may depend on the severity and complexity of the families' problems.
- Other therapeutic approaches to work with families at the edge of care, including Functional Family Therapy (FFT) and Strengthening Families Programme 10-14 (SFP 10-14) have been tested in the US and are currently being evaluated in the UK. No published studies were identified.

## **5. Targeted Youth Services (TYS)**

Targeted Youth Services (TYS) prioritise older children and adolescents (11 – 17) who experience a combination of adverse experiences and behavioural problems which may put them on the edge of out of home care, or even conflict with the law.

### **Sources:**

- Systematic review summarised in narrative form: O'Mara (2010)
- Non-systematic review: Thoburn (2009).

### **The following are key findings:**

- TYS programmes frequently improve outcomes for vulnerable youth. The most commonly identified elements of success for TYS include: a person-focused approach, communication, adequate resources, longer duration and higher intensity programmes.
- Critical to the success of most interventions is an empowered, well-trained workforce, collaborative multi-agency relationships, and effective evaluation and monitoring of the services.
- Schools are of critical importance for referrals to TYS as they can enable contact with harder to reach youth, such as those who have been excluded.<sup>33</sup>

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<sup>32</sup> These findings do not derive from a review of the literature alone but also from interviews with stakeholders.

<sup>33</sup> It is worth stressing that schools are of course critical to the identification of all children at risk.

- Outreach youth workers can be well placed to encourage teenagers to seek assistance where there is suggestion of maltreatment of neglectful parenting.
- Findings indicate the importance of reducing stigma, keeping interventions in an environment where the participant feels at home and focusing on one-to-one relationships.
- Above all, young peoples' input and participation is essential for successful design.

## 6. Cost-benefit analysis

There has been limited cost-benefit analysis in the UK context but existing studies (predominantly from the US) consistently suggest that improvement in one early outcome can yield future benefits in many different areas in a child's life; and that some outcomes lead to benefits via multiple intermediate steps (Axford 2015a).

The most comprehensive analyses have been undertaken in the US. Considerable variation in cost-benefit ratios has been reported across the range of programmes. The length of time between the early effects of an intervention and the accumulation of monetary benefit varies. In some cases, benefits are almost immediate (e.g. because there is no need for out-of-home placements), whereas in other cases, a long time passes before a particular benefit (increased retention in education, increased earning potential) is realised.

## 7. Conclusion

Although the quality of the included studies varies, this review had identified evidence of a number of effective approaches to social work practice and treatment models.

There are, however, significant gaps in the published evidence. Specifically, many new initiatives have not been the subject of any evaluation (e.g. a search using the terms MARAC or MASH produced only descriptions of these ways of working). Several new forms of practice in the UK are too recent to have generated evidence of impact at the time of writing.

# Improving the Effectiveness of the Child Protection System

## 1. Background, Aims and Objectives

The Improvement Board of The Local Government Association (LGA) wished to understand the evidence about what works in child protection, and how this can be used locally to inform decisions about how best to manage demand on Children's Social Care services using existing resources. This work has been undertaken as a joint-funded collaboration between the LGA, EIF and NSPCC.

This rapid review of the literature is Strand 1 of this project. The objective of the review is to identify

- known and emerging/innovative systems and practices involving children shown to improve outcomes for children who have experienced abuse and neglect or are at clearly identified risk of such abuse.
- effective programmes for these groups of children, in addition to evidence regarding effective methods of assessment and engagement, and practitioner training, working and management.

In this context effectiveness refers to: *“the prevention of further maltreatment or significant impairment to the child’s development. This includes both child well-being outcomes and ‘service output’ measures. These are the extent to which appropriate services are offered and taken up, to ensure that the child’s needs are met in a way which is likely to enhance their opportunity to grow and develop as they move through childhood into adult life.”* (Thoburn 2009: 3).

Where possible the review has sought to identify the reliability of evidence; scale of impact; and evidence of potential to reduce costs to children’s services and other parts of the child protection system or mitigating need for increases in spending.

## 2. Study Design

A systematic search was undertaken to identify secondary data (i.e. systematic reviews or reviews of reviews) that met the inclusion criteria below. A hand search using google and google scholar was used to identify additional studies and guidelines.

The members of the EIF steering group were sent a first draft of findings. They were asked for feedback and to recommend any further relevant studies. The paper was then sent for external review. All recommendations were considered and in most cases incorporated into the final paper.

### 2.1 Inclusion criteria

Studies selected met the following inclusion criteria:

### 2.2 Population

Children aged 0 - 21 years in any of the following categories:

- Pre-proceedings
- S17 (CiN) including children who go missing
- S47 (Child Protection)
- Targeted support (e.g. troubled families)
- CSE / targeted youth support (which may indicate existence of abuse, neglect and other harms that are not being addressed through formal child protection processes)

### 2.3 Methods of working

Studies are included that examine the effectiveness of systems and practices aimed at improving outcomes for the above groups of children. Most of the included studies involved secondary analysis of data (e.g. systematic reviews) and included studies of varying quality that addressed the topic and population of concern.

### 2.4 Outcomes

Data has been extracted from studies that had explicitly examined the impact of 2.2.2 above on a) child functioning or safety; b) system level functioning.

a) *Child functioning or safety*: This includes for example: (i) studies that had measured aspects of children's social, emotional, cognitive, or behavioural functioning; or (ii) wider aspects of physical health. Data regarding child safety includes (i) measures of parental functioning (e.g. parental mental health; parenting practices etc.) associated with risk to children; or (ii) social service outcome data (e.g. reduction or cessation of abuse/neglect; out of home placement, etc.). Measures of parental functioning were included because these are strongly associated with child outcomes.

b) *System level functioning*: This includes available evidence regarding improvements in the functioning of social care practitioners (e.g. accuracy of decision-making) or social care system (e.g. number of referrals; processing of referrals; etc.).

## 2.5 Limitations to the inclusion criteria

The search was restricted to peer-reviewed publications in the English language from 2005 – 2016. Unpublished original reports they had been peer reviewed and executive summaries of main findings had been published.

The review does not include general guidance on treatment of alcohol or substance misuse or mental health problems unless there is a specific focus on parenting. National Institute for Health and Care Excellence (NICE) evidence-based guidance is based on wide-ranging and rigorous reviews of evidence concerning effective interventions on a wide range of relevant topics, including management of drug misuse (CG51 NICE, 2007a; CG52 NICE, 2007b); alcohol-use disorders (CG115 NICE, 2011a); common mental health disorders (CG123 NICE, 2011b), and guidance on maternal mental health problems in the perinatal period (CG45, NICE, 2007).

The study does not include literature on specific forms of severe harm, including criminal offences such as trafficking, forced marriage, or female genital mutilation (FGM) that are likely to require the immediate implementation of child protection procedures.

## 2.6 Databases and search terms

A search has been undertaken using standard electronic databases including Cochrane Library; Campbell Collaboration; NICE; ProQuest (includes Medline and PsycInfo).

Grey literature has been identified using search engines such as Google Scholar. Conference proceedings or dissertation abstracts are not being sought, due to the time limitations.

Colleagues with expertise in the field were asked to read the draft and recommend any critical relevant studies that had been missed.

### 2.6.1 Search terms

ab((infant OR baby OR babies OR pre-birth OR antenatal OR perinatal OR child OR adolesc OR teen)  
AND "systematic review")  
AND (abuse OR neglect OR maltreat) anywhere in the paper.

Remaining papers were identified using Google Scholar, and hand searches of Campbell and Cochrane review databases.

### 2.6.2 Data extraction

The following data is being extracted from the included studies: author[s]; year published; study design; intervention; target group; primary and secondary outcomes; conclusion.

### 2.6.3 Appraisal of included studies

Studies were included on the basis of their content. Quality of systematic reviews was assessed by the lead author (ASM) using the CASP checklist and this information is included in the tables.

### 2.6.4 Data synthesis

A narrative summary of the findings has been produced, which includes summary text and tables detailing the key findings.

## 2.7 Results

28 reviews were selected for inclusion (see Table 1, Included Studies). Of these 5 are reviews of reviews, 19 are systematic reviews and 4 non-systematic reviews of the literature. This is the most recent evidence at this level available on topics of interest. In every case, reviews of reviews or systematic reviews were chosen over non-systematic papers. Where there was limited or no review level evidence available peer reviewed overviews of the literature were included. Further individual longitudinal, multisite evaluations were included on expert advice, as the topic areas (pre-care proceedings, short term residential care for adolescents) had not been included in systematic reviews and reference is made to individual studies or forthcoming reports that provided, or may provide, important new findings on topic areas. We have also referred to NICE evidence summaries where they are pertinent.

Evidence is organised as follows:

#### **i. Systematic and non-systematic reviews**

- Reviews of reviews
- Systematic reviews with meta-analyses
- Systematic reviews without meta-analysis
- Systematic review with narrative summary (i.e. no detailed data on included studies)
- Non-systematic reviews

#### **ii. Primary studies**

#### **iii. Other review papers** (e.g. brief guidelines)

## 2.8 Limitations

This is a rapid, non-systematic review and as such is intended to provide an overview of key findings from the most recent research available. The reader is advised to use it as an introduction to some

of the comprehensive original reports and research papers, which provide a much more detailed and discursive analysis.

There are also significant gaps in the published evidence. Specifically, many new initiatives have not been the subject of any evaluation (e.g. a search using the terms MARAC or MASH produced only descriptions of these ways of working). Several new forms of practice in the UK are as yet too recent to have generated evidence of impact.

Table 1: Included reviews

1. Axford (2015)	Review of reviews
2. Axford (2016)	Review of reviews
3. Barlow (2006a)	Review of reviews
4. BCEWH (2013)	Review of reviews
5. NICE (2015) – Chapter 9	Review of reviews
6. AI (2012)	Systematic review with meta-analysis
7. Macdonald (2012)	Systematic review with meta-analysis
8. Niccols (2012)	Systematic review with meta-analysis
9. Bailhache (2013)	Systematic review without meta-analysis
10. Barlow (2010)	Systematic review without meta-analysis
11. Barlow (2006b)	Systematic review without meta-analysis
12. Marsh (2012)	Systematic review with meta-analysis
13. Smith (2012)	Systematic review with meta-analysis
14. Turner (2015)	Systematic review with meta-analysis
15. Turney (2011)	Systematic review with meta-analysis
16. Woods (2011)	Systematic review with meta-analysis
17. Allin (2005)	Systematic review with narrative summary
18. Barlow (2016)	Review of reviews and systematic review, with narrative summary
19. Bartelink (2015)	Review of reviews and systematic review, with narrative summary
20. Macmillan (2009)	Review of reviews and systematic review, with narrative summary
21. Montgomery (2009)	Review of reviews and systematic review, with narrative summary
22. Oliver (2009)	Review of reviews and systematic review, with narrative summary
23. O'Mara (2010)	Review of reviews and systematic review, with narrative summary
24. Ward (2014)	Review of reviews and systematic review, with narrative summary
25. Dixon (2015)	Non-systematic review
26. Frost (2014b)	Non-systematic review
27. Luckock (2015)	Non-systematic review

28. McFadden (2015)	Non-systematic review
29. Thoburn (2009)	Non-systematic review

## 3. Results

### 3.1 Assessment and engagement

Practitioners need to be able to make informed decisions about

- which parents are unable to meet their children's needs
- what aspects of parents' behaviour need to change and
- whether parents have the capacity to make such changes within a timeframe that is appropriate for the child.

Decisions will be informed by an understanding of the probable impact of continuing abuse and neglect on children's life chances, and by their assessments of parents' motivation and ability to make and sustain changes to behaviour patterns that represent a risk of harm to their child. Social workers also need to consider the needs and best interest of the specific child about whom there are concerns, and recognise and address other factors (such as housing, transport etc.) that are increasing the stresses faced by the family. Careful assessment is the foundation of the work that follows; although good assessment does not guarantee successful outcomes for children, it greatly increases the likelihood of good, appropriate support that is timely (Ward 2014).

But assessment of families with serious difficulties is a highly complex task. Parents may not accept that there are problems; difficulties such as addiction, domestic abuse, or mental health problems, may be hidden precisely because adults fear the removal of their children. Parents may well be overwhelmed with practical problems, which are not their 'fault' at all, but which put children at grave risk of neglect. Assessment therefore requires a combination of relationship skills – the capacity to work alongside parents – with the need for objectivity, since the primary focus has to be the safety and wellbeing of the child/ren. This can be most challenging for professionals, who in addition to training in assessment tools require ongoing supervision and good management, and the engagement of peers in discussion and decision-making.

#### Sources:

- Systematic reviews without meta-analysis: Bailhache (2013), Ward (2012), Turney (2011)
- Systematic review with narrative summary (i.e. no data): Bartelink (2015);
- Non-systematic reviews: Thoburn (2009).

Note: Forthcoming guidance by NICE (2017) on Child Abuse and Neglect will contain an updated section on assessment of maltreatment.<sup>34</sup>

#### 3.1.1 Structured professional judgement and the assessment process

- Several reviews emphasise the need for structured professional decision-making a multi-faceted approach to assessment that includes observation, use of standardized measures, and use of multiple informants ( Barlow (2006a, Ward, 2014 and Bartelink, 2015).

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<sup>34</sup> Draft review is available at: <https://www.nice.org.uk/guidance/indevelopment/gid-scwave0708>

- There is a level of agreement about the features of families who may be most difficult to help or who are likely to continue to harm their children. But predicting which parents are most likely to abuse, or continue to abuse, children is difficult (Ward 2012).
- One review of the literature recommends beginning with a full psycho-social history of the family, to avoid the dangers of the 'start again' syndrome (Thoburn, 2009).
- Assessment must be a "relational activity" of professional engagement with children, young people and their families. Assessment should be a dynamic process in which strengths, needs, vulnerabilities and harms are identified, targets set and agreed, effective interventions identified and implemented and progress monitored over a specific time period (Ward 2014, systematic review with narrative summary).
- Professionals working with complex family problems should develop strategies to ensure that inter-professional dynamics do not mirror the family's difficulties (Turney, 2011, systematic review).
- Conceptual models are necessary to provide a framework to analyse factors that influence parents' ability to meet their children's needs and assess the likelihood of change. The transactional-ecological approach proposed by Brandon *et al* (2008, 2009) is recommended as a helpful way of thinking about the interconnecting risk and protective factors in families' lives (Ward 2014, systematic review with narrative summary).
- In cases where parents are facing complex, multi-layered problems, an integrated package of support is likely to be required, tailored to meet the needs of each member of the family (Ward 2014, systematic review with narrative summary).
- Change may not always be possible within the child's timeframe, especially when children are very young, because of the plasticity of the brain between ages of 0 and 5, or especially vulnerable for other reasons.<sup>35</sup> When parents have entrenched behaviour patterns, progress can be slow and relapse frequent. Of particular concern should be children living in homes where the following factors are present: extreme domestic abuse; where there is both substance misuse and domestic abuse and violence in the home; where children are not protected from perpetrators of sexual abuse; and/or where parents consciously and systematically cover up deliberate maltreatment (Ward 2014: 19).
- Assessment requires consideration of the individual and wider environmental problems; how multiple problems interlock; and potential impact of coercion or pressure on parents to present themselves in a positive light (Ward, 2014).

The following additional recommendations are made in a non-systematic review of the literature by Thoburn (2009).

- Managers of 'targeted' and specialist services should consider whether their assessment processes exacerbate or reduce stigma and the anxieties that parents feel.
- "Recognition *at an early stage* that a family will benefit from a lower intensity but longer-term episodic service delivered from a familiar setting avoids the alienation often caused by repeated case closure and re-referral." It also represents a considerable saving of assessment time and peaks of high anxiety for parents and children. This can be particularly appropriate

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<sup>35</sup> This should not imply that older children and adolescents are not vulnerable, particularly when they have been exposed to cumulative risk.

for families with long-term and multiple problems, and also those with a 'single issue' such as a recurring mental illness, or parents or children with a long-term disability of health condition.

#### *Barriers to assessment*

- A number of factors can hinder the process of analysis and critical thinking and undermine the exercise of professional judgment, such as for example: cognitive errors and everyday habits of thought such as fixed thinking and/or 'verificationism'; practical demands, including pressure of work and tight deadlines for the completion of assessment tasks; emotional impacts of the work on the worker (for example, the effects of fear, violence and/or stress) and systemic and organisational issues.
- Assessment tools, measures and checklists can be used to support information gathering and analysis by reminding practitioners of key areas to explore and also providing baseline data on specific issues, such as misuse of alcohol or drugs.
- Professional judgment must be supported by a sound knowledge base that includes awareness of research evidence. It is likely that analytical and critical thinking can be supported and encouraged in the context of case-based reflective supervision, which takes place in an organisational culture that supports reflecting and learning. Other forms of peer/group supervision and consultancy may also contribute to the promotion of effective thinking in practice.

#### 3.1.2 Assessing parental capacity to change

This section derives primarily from a systematic review with a narrative report by Ward (2014).

Ward (2014) report recommends an extended procedure for assessing parents' capacity to change developed by Harnett (2007).<sup>36</sup> This takes place over a period of four to six months while the family is engaged in a time-limited intensive intervention. This procedure, which measures capacity to change over a period of four to six months, directly assesses motivation and ability to change. It requires practitioners to consider any further interventions that might be necessary and identify the level of support required for change to be maintained. This model of 'capacity to change' is less concerned with a parent's report of their intentions to change and more concerned with the direct assessment of actual change. The assessment model considers the attainment of goals as evidence of parents' capacity to change, and it is this that allows for a better prediction of future family functioning.

This procedure has four elements:<sup>37</sup>

- (i) *cross-sectional assessment of parents' current functioning;*
- (ii) *specification of targets for change derived from an assessment of current strengths and deficits in the family;*
- (iii) *implementation of an intervention with proven efficacy for the client group with a focus on achieving clearly specified targets for change; and*
- (iv) *objective measurement of changes in parenting.*

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<sup>36</sup> Harnett, P.H. (2007) 'A procedure for assessing parents' capacity for change in child protection cases.' *Children and Youth Services Review* 29, 9, 1179–1188.

<sup>37</sup> Adapted from Harnett, *Ibid.*

The procedure does not, therefore, exclude a cross-sectional assessment of family functioning, but incorporates it as one element within a more extended process.

### 3.1.3 Risk Assessment Tools

Unless otherwise specified, the following summarises key findings in Ward (2014). Findings from this review were presented in narrative form.

Assessment of risk in CP cases is complex because of all the variables involved in any one case. Only a limited number of standardised tools are routinely used in a small number of local authorities in England. The best standardised actuarial instruments identified in by the review were found to be 70%-80% accurate in identifying risks of future harm, but most are much less reliable. Valid and reliable Assessment tools are a valuable aid to structured professional decision-making, but – as noted above - they cannot replace professional observation and judgment. Many assessment tools developed elsewhere require further validation in the UK before they can be reliably used.<sup>38</sup> The following is a summary of tools that were being used in the UK as of 2012.<sup>39</sup>

- **Risk assessment tools** that measure a small number of historical and static risk factors that research has shown to be strongly associated with future harm. The evidence supported the use the **California Family Risk Assessment Tool** included in the Children’s Research Centre Structured Decision-Making System (CRC-SDM), but it needs to be further validated in the UK.
- **Strengths and Needs Assessment tools** that typically measure dynamic factors that are often defined as needs and which, if remedied, can reduce the risk of harm posed. The review identified two tools developed in the UK: **the Graded Care Profile** and the **Safeguarding Assessment and Analysis Framework** which appeared most effective but need for formal piloting in the UK to test for reliability, validity, impact and acceptability.
- **Response Priority Decision Trees:** tools that are used to ‘improve the consistency across workers and to prioritise decisions about initial reports of abuse and neglect, in order to focus the workload and aid decision-making. **The CRC-SDM Response Priority Decision Trees** meet this requirement but again the review indicates that they would require testing in a UK setting.
- **Permanency/Placement and Reunification Checklists** have been developed as part of the **CRC-SDM structured decision-making system** and focus explicitly on the likelihood of recurrence of harm in relation to decisions about permanency/placement and reunification’ but also need testing in the UK.
- **Audit Tools:** similar to the risk assessment tools, but have been used to date as a means of auditing retrospectively whether cases have been classified accurately. **Ward, Brown and Westlake’s (2012) risk classification** was found to offer the most dynamic methodology for identifying risks and setting goals and timescales in consultation with parents when

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<sup>38</sup> Checklists with no evidence base are often used in assessment in the UK.

<sup>39</sup> Ward (2014) draws on a systematic review by Barlow, J., Fisher, J.D. and Jones, D. (2012) *Systematic Review of Models of Analysing Significant Harm*. London: Department for Education. There is a time lag between RCTs and review level evidence and at least one tool is currently being evaluated in the UK.

reunification is being considered.<sup>40</sup> This is currently being piloted and evaluated by the NSPCC.

### 3.1.4 Training on risk assessment tools

- Practitioners need to be trained on when and how to use assessment tools and the limitations of various measures. They may need further training in relation to identity, resilience, self-esteem, attachment, and the identification of the specific behavioural problems which contribute to poor placement outcomes for looked after children. There is a need to put assessment knowledge and skills center stage in practice, in management, and in training, learning and development (Turney, 2011).
- Parents and children may indirectly signal their need for help in a variety of different contexts. Therefore, training on communication skills that facilitate conversations with parents and children, including asking direct questions about, for example, the impact of a drug habit or a mental health problem on a child is recommended for all front-line professionals (including, for example, GPs and community nurses) (Ward 2014, systematic review with narrative summary).

### 3.1.5 Assessment of child sexual abuse<sup>41</sup>

The search revealed a dearth of evidence on social work assessment (as opposed to forensic medical assessment) of CSA. One systematic review of reviews (Bailhache, 2013) which assessed the predictive value of instruments for identifying abuse, including sexual abuse, identified only one which had accuracy of over 90% - the Structured Interview for Symptoms Associated with Sexual Abuse (SASA).<sup>42</sup> The SASA integrates twelve child symptoms to identify sexually-abused children and is applied in an interview with parents.

### 3.1.6 Emotional abuse and emotional neglect without co-occurring abuse

The identification, assessment and treatment of emotional abuse requires a multidisciplinary approach because of the complexity and multi-factorial nature of the task, and because the asymptomatic condition of some children means that problems may be difficult to identify (Barlow and Schrader McMillan, 2010, systematic review without meta-analysis).<sup>43</sup>

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<sup>40</sup> Ward, H., Brown, R. and Westlake, D. (2012) *Safeguarding Babies and Very Young Children from Abuse and Neglect*. London: Jessica Kingsley Publishers

<sup>41</sup> No systematic review was identified that dealt specifically with assessment of child sexual abuse (CSA). One review of the literature provided overall guidelines. Malhotra S and Biswas P (2006) Behavioral and psychological assessment of child sexual abuse in clinical practice. *International Journal of Behavioral Consultation and Therapy* 2:1, 17-28.

<sup>42</sup> Wells R, McCann J, Adams J, Voris J, Dahl B: A validation study of the structured interview of symptoms associated with sexual abuse (SASA) using three samples of sexually abused, allegedly abused, and nonabused boys. *Child Abuse Negl* 1997, 21(12):1159–1167.

<sup>43</sup> The FRAMEA developed by Glaser (2011) has been designed to enable assessment of the critical threshold in emotional abuse where this does not include co-occurring physical or sexual abuse or physical neglect. See: Glaser D (2011) 'How to deal with emotional abuse and neglect – further development of a conceptual framework (FRAMEA)' *Child Abuse & Neglect* 35, 866-875. ; Glaser D et al (2012) Does training in a systematic approach to emotional abuse improve the quality of children's services? Research brief. DfE. Available online: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/181602/DFE-RB196.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181602/DFE-RB196.pdf) (Accessed 12/09/16). See also Barlow J and Schrader McMillan A (2008) *Emotional Abuse*. London: Jessica Kingsley

### 3.1.7 Use of standard assessment tools with minority ethnic groups and children with special needs

A systematic review by Turney, (2011, no meta-analysis) identified a number of practice issues.

- In relation to assessments of minority ethnic children, challenges include: (i) the need to distinguish between culture and ethnicity, (ii) ensuring that interviews are conducted in the users' first language. (iii) Social workers must avoid cultural relativism and avoid misunderstand cultural practices which could leave children at risk of suffering harm.
- This review found variable practices (in terms of developing a full and detailed assessment) in relation to children who are refugees or asylum seekers, although most children did receive an initial assessment.
- Qualitative studies included in Turney (2011) found that social workers often believe there is a mismatch between the core assessment exemplars and the needs of disabled children and their families<sup>44</sup> Parents of disabled children, however, were appreciative of the core assessment process.

### 3.1.8 Engagement of children

The following is a summary of key recommendations in the systematic review by Turney (2011).

- In assessment, it is essential to keep focused on the safety and wellbeing of the child. The authors found evidence of variable practice in this regard.<sup>45</sup>
- Barriers to involving children identified in this review included: time constraints; insufficient skills; lack of confidence in conducting direct work or undertaking child observations; and insufficient support. In addition, some parents make it difficult for workers to see the child and/or overwhelm workers with their own difficulties. Children may have worries about confidentiality and the consequences of what they say for their parents.
- Numerous qualitative studies involving children consistently report that engagement of children can be enhanced by taking time to build relationships, listening to and respecting them, giving information, providing support for them to understand records or reports, and offering them real choices whenever possible.<sup>46</sup> Children's anxiety about consequences for their parents or fear for themselves must be taken into account when engaging them in assessment.

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<sup>44</sup> See for example, Mitchell, W. and Sloper, P. (2008) The Integrated Children's System and disabled children. *Child and Family Social Work*, 13 (3): 274–285; Cleaver, H. & Walker, S. with Meadows, P. (2004) *Assessing Children's Needs and Circumstances: The Impact of the Assessment Framework*. London: Jessica Kingsley Publishers.

<sup>45</sup> See for example: Horwath, J. (2002) Maintaining a focus on the child? First impressions of the Framework for the Assessment of Children in Need and their Families in cases of child neglect. *Child Abuse Review*, 11, 195-213; Boddy, J., Statham, J., McQuail, S., Petrie, P. and Owen, C. (2009) *Working at the 'Edges' of Care? European models of support for young people and families*. London: Thomas Coram Research Institute, Institute of Education, University of London.

<sup>46</sup> See for example Cleaver, H. & Walker, S. with Meadows, P. (2004) *Assessing Children's Needs and Circumstances: The Impact of the Assessment Framework*. London: Jessica Kingsley Publishers.

### **Summary:**

To assess parent's capacity to change, practitioners need to formulate a case conceptualisation, which maps out the external and internal factors that are impacting on a parent's capacity to meet their children's needs adequately. This should involve assessment over a number of time points alongside the necessary support to help parents to change, because a reliance on cross-sectional assessments provides only a 'snapshot' of the family at a particular moment in time (Ward, 2014).

Recommendations in several reviews include the consistent message that practitioners should use a combination of methods when undertaking assessments of children who have been maltreated and/or are at the edge of care. This should involve structured and shared decision-making methods that combine professional judgement, peer consultation, and the application of structured risk assessment tools. The combination of these methods should enhance consistent and accurate decision-making.

## 3.2 Motivation and retention of families in treatment

When there are serious child protection concerns and children are on the edge of care, the most difficult decisions facing social workers concern the capacity of parents to change. Parents facing multiple problems may become motivated to change in one area, but may not necessarily appreciate the need for change in others. Apparent resistance may be the result of fear, stigma (particularly around the involvement of social workers), shame, ambivalence, or lack of confidence in their ability to change. It also may be that some parents are unable to accept that they need to change, because of patterns of negative attribution that cause them to 'blame the child'.

However, even in very difficult circumstances parents can be motivated to change. The reasons for this are not entirely clear, as much of the literature around motivation to change has emerged from work on treatment of addiction, in particular drugs and alcohol, rather than parenting in highly complex families. However, it appears that motivation begins when the perceived advantages of changing the status quo outweigh the perceived disadvantages. Motivation to change can be precipitated by a turning point such as pregnancy or a crisis such as the realisation that a child may well be removed. The nature of services offered to parents, and the way in which these are delivered, can influence motivation. The following section examines current evidence on the most effective strategies to motivate parents to change.

### Sources:

- Review of reviews: Bartelink (2015)
- Systematic review without meta-analysis: Marsh (2012)).
- Systematic review with narrative summary: Ward (2014).
- Review of the literature: (Frost 2014b)

### 3.2.1 Motivation to engage

Recommendations in this section derive primarily from Ward (2014, systematic review with narrative summary) unless otherwise stated.

Skills and tasks required to promote good engagement with parents include role clarification, appropriate levels of challenge, careful listening and clarity about the purpose of the assessment. Parental involvement in all kinds of assessment depends on the worker's communication skills and ability to work with resistance. Where social workers had a good relationship with parents, the parents were more likely to cooperate with plans.

- A parent's attachment experiences may impact on the way that they engage with professionals. If unresolved, parents' experience of childhood trauma is likely to have a negative impact upon their relationships with their own children, with partners and with peers.<sup>47</sup> Insecure parental

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<sup>47</sup> Styron, T. and Janoff-Bulman, R. (1997) 'Childhood attachment and abuse: long-term effects on adult attachment, depression, and conflict resolution.' *Child Abuse & Neglect* 21, 10, 1015–1023; Turney, D. and Tanner, K. (2001). Working with neglected children and their families. *Journal of Social Work Practice*, 15(2) pp. 193–204.

attachment style will also affect engagement with professionals seeking to improve parenting capacity. Thus for example, parents with an avoidant attachment style may appear distant, may believe that others are unreliable and distrust close relationships.<sup>48</sup> This can be expressed as suspicion of 'authorities' and reluctance to build a relationship with professionals.

- One study of social support networks found that adults with avoidant attachment styles also have lower levels of support satisfaction, associated with their tendency not to open up to others and their lack of assertiveness.<sup>49</sup> The authors suggest that this lack of assertiveness may, in part, be due to adults' expectations of others' indifference towards them. An avoidant style may make it difficult for social workers to discuss issues with parents fully and gain a true picture of whether parents are coping.
- One study of parents' verbal interactions with social workers frequently carried the greatest weight in assessments of parental capability and capacity to change, with the result that those who are inarticulate or passive may be assessed as less motivated to change.<sup>50</sup> When assessing parental capacity to change, social workers therefore need to recognise that exhibiting an avoidant, ambivalent or disorganised attachment style is a foreseeable, although not inevitable, reaction from parents who have themselves experienced childhood trauma.

Many parents (as well as children and young people who have been maltreated) mistrust formal services. Parents may be resistant to the involvement of social workers rather than resistant to change in itself, particularly where they feel social workers are exercising power *over them* instead of *with them* in a supportive manner. For example, parents value social workers who use their power to help resolve practical problems.

- False compliance, failure to cooperate and denial are common. Key causes of parental resistance identified in an individual study are: social structure and disadvantage, the context of child protection work, resistance to change, denial or minimization of abuse or neglect as well as the behaviour of the social worker/therapist.<sup>51</sup> (See section 4, below). As noted in the previous section, managers of 'targeted' and specialist services should consider whether their intake and assessment processes reduce stigma and minimise the sense that parents, children and professionals will lose all control of the situation once targeted additional services are sought (in Thoburn 2009, review of the literature).
- Social workers must develop good inter-agency links with other professionals such as <sup>52</sup>health visitors and practitioners in adult services to maximise engagement with parent).

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<sup>48</sup> Riggs, A and Kaminski, P. (2010) Childhood Emotional Abuse, Adult Attachment, and Depression as Predictors of Relational Adjustment and Psychological Aggression, *Journal of Aggression, Maltreatment & Trauma*, 19:1, 75-104,

<sup>49</sup> Anders, S.L. and Tucker, J.S. (2000) 'Adult attachment style, interpersonal communication competence, and social support.' *Personal Relationships* 7, 379-389.

<sup>50</sup> Holland, S. (2000) 'The assessment relationship: interactions between social workers and parents in child protection assessments.' *British Journal of Social Work* 30, 149-163.

<sup>51</sup> Forrester, D. et al (2012) Parental resistance and social worker skills: towards a theory of motivational social work *Child and Family Social Work* 17, 118-129.

<sup>52</sup> Ward, H., Brown, R. and Westlake, D. (2012) *Safeguarding Babies and Very Young Children from Abuse and Neglect*. London: Jessica Kingsley Publishers.

Parents who are resistant to social workers may turn to other professionals who are perceived to be less threatening, or whose involvement attracts less stigma.

- Motivational interviewing (MI) provides particularly useful skills and concepts for firstly, reducing the social worker contribution to resistance and secondly, minimising the resistance that stems from other reasons, although evidence in relation to child protection is limited (Bartelink, 2015).<sup>53</sup> However, there is a wide variability in effect sizes across studies, even within the same problem areas, indicating that the way in which MI is delivered can have a substantial impact on outcomes. In relation to child protection, evidence to date supports Family Check-Up (FCU) is a brief, family-centred intervention.<sup>54</sup> Adaptation of MI to child social work involves constantly maintaining a focus on the child's welfare and safety.

### 3.2.2 Shared decision-making

Recommendations in this section derive primarily from a review of reviews by Bartelink (2015) and a narrative reviews by Frost (2014b).

Processes and models of shared decision making such as the Family Partnership Model (FP) and Family Group Decision-Making (FGDM) are used to engage parents who are ambivalent about change, mistrustful of social workers, or not fully ready for change. However, While these approaches have a strong theory of change, and consistently show high levels of user satisfaction, the evidence with respect to actual change in child outcomes is not strong at the time of writing. Participative methods such as these are delivered in a wide variety of settings and modalities, which together with relational issues and factors within the family are likely to impact on outcomes – further research is needed on these variables.

- **The Family Partnership Model (FP)** <sup>55</sup> No empirical studies were identified that measure the impact on FPM on child abuse and neglect.
- **Family Group Conferences (FGC)** Limited research one review of the literature highlight numerous studies that report on process and find with consistency that FCGs are valued by participating families, children and/or practitioners and may provide a space in which families can interact in a safe and productive way.<sup>56</sup> There is much less research on outcomes and limited, inconsistent evidence as yet of improved outcomes for children, for example in terms of reduced maltreatment.<sup>57</sup>
- **Family Group Decision-Making (FGDM)** offer a potential method of engaging parents who are ambivalent about change, mistrustful of social workers, or not fully ready for change. However, the evidence to underpin this approach is not strong (see also Dixon, 2015). While this model has potential as a tool for family engagement (and is underpinned by a

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<sup>53</sup> Forrester, Ibid.

<sup>54</sup> Dishion, T. J., Nelson, S. E., & Kavanagh, K. (2003). The Family Check-Up with high-risk young adolescents: Preventing early-onset substance use by parent monitoring. *Behavior Therapy*, 34, 553–571. \*Dishion, T. J., Shaw, D. S., Connell, A., Gardner, F., Weaver, C., & Wilson, M. (2008). The Family Check-Up with high-risk indigent families: Preventing problem behavior by increasing parents' positive behavior support in early childhood. *Child Development*, 79, 1395–1414.1

<sup>55</sup> See: Davis, H. and Day, C. (2010). *Working in Partnership: The Family Partnership Model*. London: Pearson

<sup>56</sup> Frost, N. et al. (2014b), Family group conferences: evidence, outcomes and future research. *Child & Family Social Work*, 19: 501–507.

<sup>57</sup> A forthcoming study on FGCs in South Leeds is due to be published by the University of Sheffield at the time of writing.

strong theory of change) there is as yet no evidence that it can reduce child maltreatment recurrence or out-of-home placement, and may even have a negative effect on child safety. Bartelink et al (2015) conclude that methods that *combine* shared decision-making with close monitoring of child safety (such as “Signs of Safety”, below) may be more appropriate for child maltreatment cases than family group decision-making alone.

- **“Signs of Safety”** is a solution-focused approach for maltreating families. Although initial studies have reported positive outcomes in terms of client satisfaction, child maltreatment recurrence and out-of-home placement,<sup>58</sup> there is as yet very evaluation research on this approach. Promising initial reports justify further exploration. <sup>59</sup>
- Shared decision-making may improve the participation of parents and children and the quality of decisions by taking client treatment preferences into account in addition to scientific evidence and clinical experience (Bartelink 2015). The review by Frost (2014a) and included studies stress the importance of process and recommend that in spite of equivocal findings on outcomes, participative processes such as FGCs are of value.
- Practitioners do however need be aware of the limitations of family group decision-making because it may have a *negative effect on child safety*. Practitioners should monitor child safety accurately. (It is also possible of course, that increased ‘surveillance’ of the family leads to higher levels of detection of child abuse and neglect, a point raised by Frost, 2014b). Methods that combine shared decision-making with close monitoring of child safety (for example “Signs of Safety”, may be more appropriate for child maltreatment cases than family group decision-making alone. Evidence in this review (and section 3.3.2, below) supports the use of Motivational interviewing and solution-focused interviewing techniques should be explored as a way to achieve more client participation in decision-making.

### 3.2.3 Motivation to change

Recommendations in this section derive primarily from Ward (2014, systematic review with narrative summary) unless otherwise stated.

- Qualitative data points to the part the relationship between the parent and the social worker can play not only in assessing capacity to change, but also in supporting the change process. This shows that families value child and family social workers who:
  - Are ‘not afraid to break bad news and are straightforward and honest about what needs to change and the likely consequences of failure to do so.
  - Show sensitivity
  - Are prepared to listen to their point of view and understand their circumstances.

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<sup>58</sup> Turnell, A. (2008). *Adoption of Signs of Safety as the department for child protection’s child protection practice framework*. Perth: Government of Western Australia (Department for Child Protection); Turnell, A., & Essex, S. (2006). *Working with ‘denied’ child abuse. The resolutions approach*. Maidenhead: Open University Press.

<sup>59</sup> Further research in the UK has been commissioned by the NSPCC is currently underway

See: NSPCC: <https://www.nspcc.org.uk/globalassets/documents/research-reports/signs-safety-england.pdf>

A study is also being undertaken by the Australian Centre for Child Protection (ACCP) at the University of South Australia. See: <http://www.signsofsafety.net/research/>

- Use their power to support families rather than to penalise them;
  - Offer practical support and advocacy.
  - Work from a strengths perspective: An approach which underlines parental deficits is more likely to lead to resistance than one which focuses on and reinforces positive behaviours and acknowledges the challenges parents are facing.<sup>60</sup>
- There is *no guarantee* that engagement with services will lead to change. Change occurs when the decisional balance reaches a tipping point and the potential gains are perceived as outweighing the anticipated losses. Clarifying the perceived advantages and disadvantages of change may help practitioners and parents understand why change is so difficult and how it might be facilitated.
  - Some parents will experience events or circumstances that create a turning point in their lives and motivate them to make the changes needed to overcome adverse behaviour patterns and improve their parenting. Turning points provide opportunities to promote and support change.
  - Ward (2014) observes that there will usually be a level of coercion in statutory interventions where children are suffering, or likely to suffer, significant harm. Coercion help parents realise that change must happen. However it can also have negative consequences if parents who are uncertain about their capacity to change become further entrenched in adverse behaviours that shield them from their painful reality.
  - When combined with a package of timely, co-ordinated interventions from a range of professionals, the authority of the courts and informal pressure from friends and family members can play a constructive role in motivating parents to change.
  - An increasing range of effective intensive interventions aimed at improving parenting skills or addressing other specific problems, for instance, drug or alcohol misuse, can complement social work support to a family. These are covered by NICE guidelines.<sup>61</sup>
  - Interventions designed to increase parenting skills can be effective and can have a positive knock on impact, reducing other parental problems by increasing self-efficacy and self-esteem.
  - Outcomes may to be influenced by other variables, such as the setting of the intervention. One review included two interventions delivered in 'traditional social welfare settings' and two in home settings (Marsh, 2012). Those delivered in 'traditional social welfare settings' reported mixed findings, with greater safety but not permanency or wellbeing. In contrast, the two studies delivered in the home, which had a slightly more preventive focus and were not court mandated, found more consistent associations among the client-provider relationship and measured outcomes.
  - Nonetheless after parents have become motivated to change and engage with services, intensive support programmes to address specific problems may last several weeks or months, and relapses are common within the first three to six months of completion. Much of this work needs to be undertaken before the decision is made to instigate proceedings.

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<sup>60</sup> Forrester, D., Westlake, D. and Glynn, G. (2012) 'Parental resistance and social worker skills: towards a theory of motivational social work.' *Child & Family Social Work* 17, 2, 118-129.

<sup>61</sup> Ibid.

### 3.2.4 Preventing relapse

Recommendations in this section derive primarily from Ward (2014, systematic review with narrative summary) unless otherwise stated.

- A key factor in the recovery and change process is the establishment of “virtuous circles” in which success in one area leads to success in others.
- Internal factors supporting the maintenance of change include certain demographic factors; self-efficacy; having a ‘normal’ role in society. External factors include positive support networks and appropriate support from professionals.
- Internal factors that undermine the maintenance of change include stress, negative emotions, and co-existence of problems. External factors include isolation, inadequate support networks and poverty.
- Parenthood is a key motivator in sustaining change; however, if parents are inadequately supported, the stress of resuming greater parental responsibilities can undermine progress.
- Parents’ priorities are likely to change as they progress through recovery, so different factors will be relevant at different stages of that process.
- Change or recovery in one area of life does not automatically result in improvements to other areas.
- Recovery from problems such as substance misuse is a gradual process extending over a period of years rather than a time limited event. Relapse is often part of the recovery cycle.
- Relapse may have a negative impact on children’s wellbeing because they may be at risk of immediate harm; continuing exposure to abuse and neglect may compromise their development; and they may experience significant harm. As noted earlier, assessments will need to consider whether, in view of what is known about the child’s needs, the issues parents face, the factors which increase or decrease the likelihood of relapse, and the support available for the future, enough change can be achieved and sustained within the child’s time frame.

#### Summary:

Long-term behaviour changes require intrinsic motivation on the part of the parents. The ability of parents to change, and to sustain change in the long run depends on the nature and complexity of the problems they are trying to overcome.

The relationship between parent and worker can have a strong influence on the parent’s engagement with services, although it does not necessarily predict outcomes (Marsh, 2012). As with assessment, this requires a balance between understanding, respect and recognition of families’ strengths, with honest communication about what needs to change, when, and why.

Shared decision-making seems to be an effective way for client participation in decision-making. This method seems particularly important to achieve long-term improvements in clients. At present, evidence to support the Family Partnership Model (FP) and Family Group Decision-Making (FGDM) is not strong. In contrast, authors of a recent high quality review of reviews (Bartelink 2015) recommend that motivational interviewing be useful as part of a shared decision-making process and should be explored further as a way to achieve more client participation in decision-making. “Signs

of Safety” is a solution-focused approach for maltreating families. Although initial studies report positive outcomes on client satisfaction, child maltreatment recurrence and out-of-home placement, no peer-reviewed studies have yet been published.

### 3.3 Practitioner role, management and training

This section looks at evidence on the way that the service provider or social worker's relationship-building skills, and their capacity to manage difficult situations, can contribute to treatment outcomes.

It also considers what staff need to work most effectively in what is an inherently stressful job. Child protection social work can result in burnout, and rapid staff turnover is detrimental to sustained work with families. It is therefore important to look at the structural and operational factors that help staff to function well, and the training required in professional preparation and in service, that can help build workers' resilience and promote their job satisfaction.

#### Sources:

- Systematic reviews with meta-analysis: Al (2012); Niccols (2012); Macdonald (2012)
- Systematic reviews without meta-analysis: Marsh (2012), Turney (2015)
- Reviews with narrative summary: Ward (2014)
- Non-systematic reviews: Macmillan (2009); McFadden (2015)

#### 3.3.1 Client provider relationship and treatment outcomes

Comparative and longitudinal studies summarised in Ward (2014, a systematic review with narrative report) identified that social work interventions for maltreated children are more likely to be successful if:

- thorough and timely assessments can: (i) lead to the identification of clearly specified goals and targets concerning what needs to be changed (ii) provide parents with support they need to have the chance to overcome adverse behaviour patterns within an appropriate timeframe.
- both social work and specialist services are combined to support such changes;
- interventions include careful planning that includes children and families;
- there is strong proactive case management.

The quality of the relationship between practitioner and client was found to consistently predict better participation and retention in three studies involving child welfare but that it is less predictive of outcomes (Marsh, 2012, systematic review).

Evidence about the characteristics of *ineffective* relationships between social workers and parents, identified in studies of serious case reviews, indicates that the relationship can become dysfunctional if the social worker's decisions are influenced by:

- unrealistic expectations of families' capacity to change
- overt hostility from parents
- cultural relativism, which is sometimes used to condone abuse or neglect

#### 3.3.2 Factors associated with staff retention

The following section summarises key messages in McFadden (2015, review of the literature) unless otherwise other sources are specified.

Staff retention is associated positive coping styles and personal development, good-quality primary and ongoing training, constructive organisational cultures, supportive social and supervisory support, together with manageable workloads.

Major predictors of turnover are less to do with individual level factors but at the quality of the organisation and how this affects work. A major contributor to staff burnout is an excessive workload and being stretched beyond capacity.

- Supervisor and peer support are significant influence commitment, shape organisational culture and influence the intention to stay or leave. Whether or not these factors are present varies from authority to authority.
- Differences in organisational cultures can be reflected in the nature of supervision, which in some authorities still focuses more on performance management than on the development of reflective practice.
- A systematic review with narrative summary by Ward (2014) identified care planning as an area of weakness reported in several included studies. For example, plans for maltreated children who return home from care are often unrealistic, with children frequently returning to parents who have been unable to overcome the behaviour patterns that precipitated the original removal.
- Weaknesses in training include the fact that child development is not a mandatory part of many social work training courses.
- A 'personal history of maltreatment' can impact on workers who are dealing with vicarious trauma. Personal awareness and personal development are important at the point of entry onto this career, for individuals and educators as well as employers, and this commitment should be a career-long activity. Although it cannot be assumed that all motivation to a social work career has an origin in a personal history of trauma, consideration could be universally applied to anticipate the needs of workers who have experienced trauma.
- Differences in organisational cultures can be reflected in the nature of supervision, which in some authorities still focuses more on performance management than on the development of reflective practice. There are also wide variations between authorities. These are likely to relate to the prevalence of a number of organisational factors that have been identified as barriers to effective social work practice.
- However, high levels of staff retention are not *invariably* indicative of a health organisation; in some cases, workers remain and work at less than optimal levels because there are no other comparable jobs available in the area (McFadden, 2015).

Changes of social worker have also often been noted as detrimental to successful case management because they obstruct the development of constructive, supportive relationships with parents and children, and the implementation of plans. Such changes reflect the widespread use of agency staff, the high turnover of more permanent staff, and the organisation of services, which often require cases to be transferred from one team to another as families move through the system.

Pressure to close cases, frequently due to restricted resources means that social work interventions are often relatively short term. Moreover, both social work and more specialist interventions tend to end abruptly with often inadequate arrangements for long-term, less intensive support or monitoring of children's circumstances.

### 3.3.3 Training, learning and development

The following section summarises key messages in a non-systematic review of the literature by McFadden (2015) unless otherwise specified.

#### *Social work qualifying courses:*

- Child (and especially adolescent) development is still not covered thoroughly in all social work qualifying courses, many of which fit the subject within a broader curriculum of human growth and behaviour or lifespan development.
- Training at undergraduate and postgraduate levels should include practice placements and preparation for practice should reflect the demands, challenges and realities of the job.
- Workers need to develop internal resilience by engaging in personal and professional development strategies from the outset of their career so that they can build on these to develop active coping methods and practices.
- Undergraduate and post-qualifying training need to include training that will enhance resilience.
- Training needs to explore the inherent conflicts in the social worker's role, such as how statutory responsibilities to define and act on child protection concerns can be reconciled with values that emphasise the importance of empowering parents.

#### *In service training*

Employers and policy makers are advised to develop a strategic approach to build resilience into the workforce.

- One review finds some evidence that improvements in perceived competence can be translated into changes in clinical practice, as documented by clinical record audits. However, perceived competence gains are not sustained consistently over time, indicating the need for reinforcement (e.g. booster sessions) (Turner, 2015, systematic review without meta-analysis).
- Training transfer research highlights the need for supervisor support and an organisational climate that encourages and accommodates learning. Some studies have identified deficiencies in training, in terms of too little attention being given to the acquisition of up-to-date knowledge in areas such as the impact of abuse and neglect on childhood development and risk and protective factors in families where children are likely to suffer significant harm. Further resources and training may be required by practitioners to improve their

understanding of issues such as the impact of substance misuse, or neglect, on children (Turner 2015).

**Summary:**

Changes of social worker can be detrimental to successful case management because they obstruct the development of constructive, supportive relationships with parents and children, and the implementation of plans. Such changes reflect the widespread use of agency staff, the high turnover of more permanent staff, and the organisation of services, which often require cases to be transferred from one team to another as families move through the system.

Staff retention is associated with good management. Burnout and rapid turnover appears to be more strongly influenced by a lack of adequate supervision, peer support and organisational issues more than the inherently challenging nature of the work. Conversely, it is associated with constructive organisational cultures, supportive supervision, and manageable workloads.

Professional and in-service training needs to include practical skills on managing stress and developing resilience. Resilience increases with the application of active, positive coping styles, and through personal development, including regular good-quality primary and ongoing training. Professional training needs to take into account the impact of child protection work at a personal level, as a proportion of students will themselves have had a history of abuse.

### 3.4 Innovative Models of Practice

The importance of an integrated approach to safeguarding is widely understood, with a continuum of prevention and multi-agency responses designed to address the level of risk identified together by practitioners in conjunction with children and parents. The intention is to allocate inter-professional authority and resources in a way that ensures that safeguarding is proportionate to the nature and level of concerns raised and effective in achieving good outcomes for children and for parents (Luckock, 2015). In practice, however, collaboration and dialogue cannot be assumed when concerns about child safety well-being arise.<sup>62</sup> Problems can include concerns across the NHS about impact on their relationships with families if they make a referral, concern about sharing information, and whether the response might be sufficiently adequate and timely. There are also contrasting interpretations of priorities and practice across child and adult mental health and social care.

A number of innovative service models and practice methodologies have been proposed in order to provide a more risk sensitive and timely response, and to reduce further likelihood of error. The composition, structure, accountability and scope of Local Safeguarding Children's Boards (LSCBs) have been the subject of a recent report by Wood, (2016).<sup>63</sup> The government will be developing a new statutory framework which will clarify and strengthen the role and mandate of local LSCBs, enabling local partners the freedom to decide how they operate to improve outcomes for children within agreed standards. However, there is as yet limited evidence in relation to models of practice in the UK, particularly in terms of child and family outcomes.

#### Sources:

- A systematic review reported in narrative form by Luckock (2015).
- Non-systematic review of the literature by Thoburn (2009).

This section also includes some key findings on pre-care proceedings from an individual study by Masson (2013).

#### 3.4.1 Common factors

- *Government audits* suggest that innovative models are more likely to be found where adult substance misuse intersects with child safeguarding. However, only three studies that described this were identified: two integrated family support projects and one court-based team (Luckock 2015).
- The common factor for all promising innovations is the quality and integrity of the dialogue among all stakeholders, but particularly between the lead practitioner, parents and child(ren). The quality of this dialogue can be facilitated not only by the skills of lead practitioner but also by the service design. Decisions about the approach to service provision, and the specific methods and service components that have the best chance of being effective, have to be based on analysis of dialogue among stakeholders as well as periodic reassessments (Luckock, 2015; Thoburn, 2009).

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<sup>62</sup>Davies C and Ward H, 2012 *Safeguarding Children across Services*. London: Jessica Kingsley.

<sup>63</sup> Wood, A. (2016) *Review into the Role and Functions of Local Safeguarding Boards*. London: Department for Education. See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/526329/Alan\\_Wood\\_review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf) (Accessed 12/01/17); Department for Education (2016) *Review into the Role and Functions of Local Safeguarding Boards. The Government's response to Alan Wood CBE*. London: Department for Education. See: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/526330/Government\\_response\\_to\\_Alan\\_Wood\\_review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526330/Government_response_to_Alan_Wood_review.pdf) (Accessed 12/01/17)

- *Speedy access* to services and the *intensive, structured and time-limited* nature of specialist joint team working are identified as common factors crucial to the success demonstrated, including some follow up of child outcomes (Thoburn, 2009).

**The following methods of multiagency working across sectors are identified in Thoburn (2009)** (see also section on Assessment, above).

- Screening:** routine/universal health screening is enhanced by specifically screening for maltreatment. Survey data shows the importance of formal links between hospitals and social work/community based expertise.

Emerging evidence shows that traditional modes and tools of risk assessment at the service interface are being re-introduced in the new policy context. (See also section on Assessment). However, two functions of standardised tools – to stimulate dialogue and to reach a diagnosis – need to be reconciled, particularly where the relationship between the parent and the practitioner is not (yet) strong.

- Common assessment.**<sup>64</sup> Surveys confirm that a standardised model of ‘common assessment’ (CAF) has become the prevalent methodology within a ‘whole systems’ service integration in the UK.

Evidence suggests that common assessment can have positive and negative effects: (i) Common assessment has the potential to enable parental engagement and risk de-escalation in some cases or (ii) it can lead to reduction in the quality of workers’ relationship with families because of the day-to-day demands of adhering to the procedure in practice.

- Multi-agency team working:** includes ‘virtual’ and ‘co-located’ teams, in some cases led from within ‘adult social care’ services.

Multi-agency team working was rarely reported at the interface of adult health, adult social care and children’s social care services as of the time of writing (systematic review with a narrative summary by Luckock, 2015). One study suggests that implementation is enhanced more by the quality of the dialogue and relationships than by the use of a dedicated ‘champion’ positioned at the service interfaces. ‘Relational working’ was also central to the reported success of a court-based project for parents with learning disabilities.

Specific recommendations on interagency approaches to prevent, assess for and respond to domestic violence are outlined in NICE (2014).<sup>65</sup>

### 3.4.2 Evidence-based models of working

- **Community-based models of practice designed to create better integration between child protection services.** This includes the integration of Sure Start children’s services with targeted child and family services for families referred because of child protection concerns. An important contributor to more successful centres was the attachment of a

<sup>64</sup>See: <https://www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters.pdf> (Accessed 12/11/16).

<sup>65</sup> NICE (2014) *Domestic Violence and Abuse: Multi-Agency Working*. London: NICE. Available online: <https://www.nice.org.uk/guidance/ph50/chapter/7-glossary> (Accessed 04/02/17)

child and family team social worker, who modelled the link between generally available services with specialist child protection and looked-after services.

- **Neighbourhood family centres, combining drop-in support and parenting training with 'targeted' outreach services:** evaluations indicate that these can be successful in working collaboratively with some families with very complex problems,<sup>66</sup> Services include practical assistance (including financial support and subsidised day care), educative and therapeutic group work for parents and children, and relationship-based casework. "The centres are designed to 'hold the ring' between family members' support and protection needs, possessing sought-after knowledge about the needs and preferences of parents, experience of the tasks involved in constructing local service networks and skills in joint working" (Thoburn 2009: 10).
- **Co-working in a team around the child and family' case:** this requires vigilant, challenging, knowledgeable and empathic coordination and supervision of all workers and volunteers.<sup>67</sup> Particular care needs to be taken to ensure that parents are not able to draw their allocated worker into collusive situations that can lead to a loss of focus on the child. A co-working model, with two workers sharing the lead professional role for the family as a whole, is another possible approach developed from family therapy.

### 3.4.3 Pre-care proceedings

The following section draws on a single multisite longitudinal multisite study by Masson et al (2013), providing data on 207 observed cases were followed up 6-18 months after the first contact.

- Use of the pre-proceedings process varies between local authorities. Those in the study used it in almost all cases where there was time to do so - around half of all cases where care proceedings were started.
- A third of pre-proceedings cases involved pre-birth assessments. Meetings were used to agree assessments, services and /or alternative care.
- Use of the process was supported by social workers and their managers who saw it as a more respectful way to work with families at risk of care proceedings.
- Parents felt supported by having their lawyer at the pre-proceedings meeting; for some this helped them to engage with children's services and improve care.
- The pre-proceedings process can succeed in diverting cases from court. Based on the file sample in this study, about a quarter of cases did not enter care proceedings; in a third of children were protected by kin care or foster care; and two-thirds by improvements in care at home.
- The pre-proceedings process delayed decisions for children who entered care proceedings. Court applications were delayed by attempts to use the process and sometimes by failure to recognise family care was not improving.

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<sup>66</sup> Tunstill, J., Aldgate, J. and Hughes, M. (2006) *Improving children's services networks: lessons from family centres*, London: Jessica Kingsley; Berry, M et al. (2006) 'Identifying sensitive outcomes of interventions in community-based centres', *International journal of child and family welfare*, 9, 2–10.

<sup>67</sup> Burton, S. (2009) *Safeguarding briefing 3: The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information?* London: C4EO.

- However, care proceedings were not shorter where the pre-proceedings process had been used. Courts did not appear to take particular account of this work.
  - See for example: **Pre-care proceedings:** <http://childprotectionresource.online/tag/pre-proceedings/>

#### 3.4.4 Other possible models introduced which merit evaluation in the UK

- A single worker with a very small case load and 24-hour availability of supervision/consultation, as in the intensive family preservation models developed in the USA and adapted in some agencies in the UK, including some of the family intervention projects.<sup>68</sup>
  - See for example: **Intensive family preservation services:** <http://www.intensivefamilypreservation.org/about/> (The oldest of these is Homebuilders – discussed below; adapted in the UK as Homebuilders Option 2.)
- Combining an ‘as long as needed’ key worker outreach services with a drop-in facility: evidence to support this has been found in evaluations of the approach used by the Kids Company and Action for Children.<sup>69</sup> There is some evidence from these studies that solution-focused methodologies, when delivered by committed and empathic practitioners, can benefit families with complex needs, and are generally viewed positively by family members (Thoburn 2009).
  - See for example: **an Action for Children drop in centre:** <https://services.actionforchildren.org.uk/torridge-childrens-centres/whats-on/childrens-centre-drop-ins/>

As noted in the previous section, continuity of social support is essential for complex families in which change is hard to achieve or maintain. This justifies a move from a functional model to a community-based model of case allocation. However, increasing the availability of social support to especially vulnerable families is a *supplement* not a substitute for a social casework service.<sup>70</sup>

### Summary

The general case management and family support provided by social workers in England has not been formally evaluated (Macmillan *et al.*, 2009). Where evidence of effectiveness exists it is often relatively weak and needs to be pieced together from studies where this issue was peripheral to the main focus of the research. Nevertheless, comparative studies and evaluations that make use of survey and case file data and interviews with professionals show that interventions can be effective if they involve careful assessments that lead to clearly specified goals and targets; involve provision of both social work and specialist services; and involve children and families in planning, leading to the identification of clearly specified goals and targets concerning what needs to be changed; and strong case management (Ward 2014).

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<sup>68</sup> Brandon, M. and Connolly, J. (2006) ‘Are intensive family preservation services useful?: A UK study’, *Journal of family preservation*, 9, 56–69; Schuerman, J. R., Rzepnicki, T. L. and Littell, J. H. (1994) *Putting families first: an experiment in family preservation*, New York: Aldine de Gruyter; Social Exclusion Task Force (2007) *Reaching out: think family*, London: Cabinet Office; Tunstill, J. and Blewett, J. (2009) *The delivery of targeted family support in a universal setting*, London: Action for Children.

<sup>69</sup> Gaskell (2008) *Kids Company help with the whole problem*. London: Kids Company; Tunstill, J., Blewett, J. & Meadows, P. (2009) *An Evaluation of the Delivery of Targeted Family Support by Action for Children*, London: Synergy Research and Consulting Ltd.

<sup>70</sup> Gaudin, J. M. (1993) ‘Effective intervention with neglectful families’, *Criminal justice and behavior*, 20, 66–89; Ghate, D. and Hazel, N. (2002) *Parenting in poor environments: stress, support and coping*, London: Jessica Kingsley

Although there is very little research evidence on the relative effectiveness of different models, the literature draws attention consistently to the importance of dialogue among all stakeholders in the safeguarding process. Clear, consistent and open communication is a common factor to enabling children, parents and professionals to recognise and respond to areas of concern in a way that is acceptable to all, and which can lead to effective change. The lead professional needs to ensure that relationships between children and parents are developed in such a way that dialogue can be sustained (Luckock 2015).

### 3.5 Effective programmes and interventions with children and families at the edge of care

Note: Forthcoming NICE (2017) guidelines on Child Abuse and Neglect will provide more detailed evidence on interventions. Although these guidelines are not yet complete, this section includes draft recommendations from this unpublished guidance where new programmes have been evaluated.<sup>71</sup>

There is a large and growing evidence base addressing ways to prepare parents for the challenges of parenting from the antenatal and postnatal period through to adolescence. Much of this literature has focused on parents in demographically high risk groups (e.g. young, single parents in poor environments) or parents who lack experience with challenges such as managing toddlers, mealtimes, children's externalising behaviour or communicating with teenagers. There is also some review level evidence on the impact of such programmes when delivered to families with complex needs, parents of children on the edge of care, or where there are concerns about specific forms of maltreatment.

Munro (2011)<sup>72</sup> highlights the fact that evidence-based practice is not simply a case of taking an intervention "off the shelf" and applying it to a child and family; or as Woods (2011: 53) puts it "research evidence on the effectiveness of an intervention... with particular types of child and family problems, provides a starting point, rather than the final word, for effective and safe practice"). Multi-faceted programmes for families with complex needs should to be dovetailed with other services and to be part of a child protection plan that reflects the need to step-up and to step-down the intensity of support as required. Not all children in families with a complex web of long-term problems will benefit, but trials have shown that more children will benefit, and to a greater degree, than those who receive routine services.

- *For further information on specific interventions and therapeutic approaches, please follow links to external webpages. The detail and source of information differ according to what is available online. The inclusion of these is intended for general guidance only, and is not an endorsement of any particular service provider.*

#### Sources:

- Review of reviews: NICE (2015); BCCEWH (2013); Barlow (2006a)
- Systematic reviews with meta-analysis: Al (2012); Niccols (2012); Macdonald (2012)
- Systematic reviews without meta-analysis: Barlow and Schrader-McMillan (2008); Smith (2012); Woods (2011); Barlow (2006b); Turney (2011); Barlow (2016)
- Systematic reviews with narrative summary: Allin (2005) Montgomery (2009); Oliver (2009); Ward (2014).
- Non-systematic review: Macmillan (2009)
- Individual scoping study: Dixon (2015)

#### 3.5.1 Interventions

- When manualised interventions are offered in the UK to families with complex needs, these are often one of several services provided, or they are provided alongside social casework and the 'team around the child' (systematic review by Turney (2011).

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<sup>71</sup> Drafts are available at the time of writing on: <https://www.nice.org.uk/guidance/indevelopment/gid-scwave0708>

<sup>72</sup> Munro, E. (2011). *The Munro Review of Child Protection (Final Report): a child centred system*. Norwich: The Stationery Office.

- The first line of treatment should be to improve the relationship between carer and child. The evidence points to the value of *parent-focused interventions that are underpinned by clear logic models* (theories of change) geared to strengthening the parent-child interactions and reducing child conduct problems (REF).

Evidence on “effective” intervention, and on the optimal duration and form of delivery, emphasises the importance of addressing the needs of individual families, and specifically, the need to take into account of the clients attachment history (Ziv, 2005).<sup>73</sup> For example, early findings suggest an association between adults scores on a measure of attachment security and their responses to different therapeutic approaches such that parents classified as ‘avoidant’ were better suited to behavioural type interventions whereas parents classified as ‘preoccupied’ were better suited to interventions targeting internal working models.<sup>74</sup>

The success of any intervention depends on a number of common elements, the most important of these being the quality of the therapeutic relationship (REF).

The following is an outline of programmes and interventions recommended as part of an integrated package of (time limited) support for families with a child on the edge of care.

#### *i. Promoting parental sensitivity/attachment security in maltreated children*

Most research on promoting attachment security in children at high risk focuses on children under the age of five. In general, evidence supports interventions that are relatively short and have a behavioural focus that aims at improving parental sensitivity in order to promote children’s attachment security (NICE, 2015, review of reviews; Barlow 2016).

The NICE (2015) review on interventions with *children on the edge of care* included 11 RCTs of video feedback; 5 RCTs of parent-child psychotherapy; 9 RCTs of parental sensitivity and behaviour training; 23 RCTs of home visiting; 1 RCT of parent CBT; 2 RCTs of parent psychotherapy; 1 RCT of parent non directive counselling. Interventions for *children who had been maltreated* included: 4 RCTs of home visiting; 2 RCTs of parent child psychotherapy; 2 RCTs of video feedback. Barlow (2016) included on review of reviews and four further individual studies of attachment-focused interventions involving parents and young children where there are child protection concerns.

The following is a summary of evidence:

- *Video feedback:* There is robust evidence to support video based interventions with to promote parental sensitivity and child attachment security.<sup>75</sup> However, to date, the evidence around video based interventions in cases of identified child maltreatment is based on limited research of low quality. These have reported improvements in parents’ capacity for sensitivity and responsiveness towards maltreated children . The evidence is inconclusive with respect to improvements in children’s internalising and externalising behavioural problems.
  - See: **Video Interaction Guidance (VIG)** <http://www.videointeractionguidance.net/> **Videofeedback for positive parenting:** <https://tavistockandportman.nhs.uk/research-and-innovation/our-research/research-projects/video-feedback-intervention-promote-positive-parenting-and-sensitive->

<sup>73</sup>Ziv, Y (2005) Attachment-Based Intervention programs: Implications for Attachment Theory and Research. In Berlin et al (Eds), *Enhancing Early Attachments: Theory, Research, Intervention and Policy*. Guilford Press, London.

<sup>74</sup>Bakermans, M., Juffer, F., & van IJzendoorn, M. H. (1998). Interventions with video feedback and attachment discussions: Does type of maternal insecurity make a difference? *Infant Mental Health Journal*, 19(2), 202–219.

<sup>75</sup> See: Fukkink, R. G. (2008). Video feedback in widescreen: a meta-analysis of family programs. *Clinical Psychology Review*, 28(6), 904–16. Available on: [http://www.juconicomparte.org/recursos/Video%20feedback\\_fwW8.pdf](http://www.juconicomparte.org/recursos/Video%20feedback_fwW8.pdf)

discipline-research. See: - **Video-intervention to promote positive parenting and sensitive discipline (VIPP-SD)** <https://tavistockandportman.nhs.uk/care-and-treatment/treatments/video-feedback-intervention-promote-positive-parenting-vipp/>

- *Parent-child psychotherapy (PCP)*: There is low quality evidence that Parent-Child psychotherapy can increase the attachment security of preschool children and can reduce maternal maladaptive representations.
  - *Parental sensitivity and behaviour training (PSBT) with preschool and primary school aged children*. Studies of low quality find evidence favouring PSBT in terms of increasing parent's sensitivity, reducing their harmful and negative behaviour, and improving child externalising behaviour. There is no evidence for effectiveness on children's internalising behaviour. Low quality evidence favours PSBT in terms of reducing reoccurrence of abuse.
    - See: **Parental sensitivity to child behaviour** [https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/teaching/Disabilities/families-too/Parenting/disabl\\_pub\\_00029\\_081806.html](https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/teaching/Disabilities/families-too/Parenting/disabl_pub_00029_081806.html). Models include video-guided interventions – discussed below)
  - *Trauma focused cognitive behavioural training vs parent child psychotherapy (PCP) with primary and secondary school aged children*. Low quality evidence suggests that trauma based cognitive behavioural therapy is more effective than PCP in improving children's internalising problem behaviours. There is inclusive evidence with respect to the relative efficacy of either intervention on children's externalising behaviour.
    - **See: Trauma focused CBT** <http://www.goodtherapy.org/learn-about-therapy/types/trauma-focused-cognitive-behavioral-therapy>; parent child psychotherapy: <http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed>)
  - *Mentalization based treatment*. Minding the Baby, a mentalisation based home visiting intervention focused on improving the reflective functioning of first-time mothers aged 14–25 experiencing a range of problems during the perinatal period, including child protection issues, depression, homelessness, poverty or violent relationships. 'Mentalisation' refers to the ability to understand behaviour in terms of mental. MTB is delivered by two trained practitioners (a qualified nurse and social worker alternate) for an hour a week, from the third trimester of pregnancy until the infant is 2 years of age. One RCT involved 11% of mothers had child protection concerns. Significantly higher infant security was reported in MTB vs intervention infants. MBT mothers had fewer instances of rapid subsequent childbearing and a trend towards fewer open cases with child protection services. There were no significant differences between groups in maternal reflective functioning, depression or psychological distress.
    - **See: Minding the Baby**: <https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/minding-the-baby/>
- Approaches that are contraindicated*
- In addition to identifying evidence of effectiveness, NICE guidelines also identify approaches that should not be used, because they could cause harm to children. These include: (i) any form of therapy' that involves physical coercion or restraint (such as 'holding therapy') or (ii) aversive stimulation.

## ii. *Cessation of physical abuse*

There are several problems in assessing the effectiveness of interventions with families where a child has been physically abused including the fact that relatively few studies have used objective measures of physical maltreatment, and most studies only measure risk factors (such as parental behaviour and attitudes) that are associated with abuse as opposed to direct measures of abuse (review of reviews by Barlow, 2006a; systematic review without meta-analysis by Barlow 2006b). Reliance on a parent's self-report can be problematic, because parents with a history of child abuse may have minimised problems in pre-test self-assessment measures - and this can result in an inaccurate measurement of the intervention effect (Oliver, 2009).

- The most consistent evidence supports the use of Parent Child Interaction Therapy (PCIT) in improving some outcomes associated with physically abusive parenting.<sup>76</sup> This is reported in six papers: a review of reviews by Barlow (2006a); a systematic reviews without meta-analysis: (Barlow, 2006b); two systematic reviews with narrative summary (Oliver, 2009; Ward 2014); and one non-systematic review (Macmillan, 2009) PCIT is an individualised intervention developed for parents and children with behavioural problems aged 4-7 years which involves parents and children in conjoint sessions that include direct coaching and practice of skills.
  - See **Parent child interaction therapy**: <http://www.pcit.org/what-is-pcit1.html>
- A small number of studies in a high quality review suggest that the combination of parenting programmes with additional components to address problems associated with abusive parenting are more effective than parenting programmes that do not incorporate these components (Barlow 2006a, review of reviews). Problems that need to be addressed alongside parenting include: parents' dysregulated anger, misattributions, and poor parent-child interaction. There is evidence to support an enhanced version of the Webster-Stratton Incredible Years Program in improving some outcomes associated with physically abusive parenting<sup>77</sup> (Barlow, Ibid; Macmillan 2009). Additional components focused on emotional regulation and other risk factors associated with physical violence (Barlow (2006a). Barlow (2006a) therefore advises combining home visiting with cognitive behavioural therapy to help regulate parents' negative emotional states (e.g. excessive parental anger, misattributions, and poor parent-child interaction)
  - See for example:
    - **Home visiting (range of programme)s**: <http://www.cebc4cw.org/topic/home-visiting-for-prevention-of-child-abuse-and-neglect/>;
    - **CBT for families**: <http://www.cebc4cw.org/program/alternatives-for-families-a-cognitive-behavioral-therapy/>
    - **Incredible Years**: <http://www.cebc4cw.org/program/the-incredible-years/>;
    - **Triple P**: <http://www.cebc4cw.org/program/triple-p-positive-parenting-program-system>.
- There is evidence to support the use of multi-systemic family therapy in improving a range of outcomes (MSFT) (Barlow 2006a, review of reviews; Dixon 2015, scoping study). Studies in the US have found that MSFT is significantly more successful than normal services in improving family relationships and in reducing both the short and long-term rates of re-offending amongst serious young offenders. Limited research in the UK has found it effective in the reduction of offending, and of aggressive and delinquent behaviours based on parent-reports (Dixon, Ibid).

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<sup>76</sup> See for example: Chaffin M et al. (2004) Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports. *J Consult Clin Psychol* 72: 500-10.

<sup>77</sup> See for example: Hughes JR and Gottlieb LN. (2004) The effects of the Webster-Stratton parenting program on maltreating families: fostering strengths. *Child Abuse Negl* 2004; 28: 1081-97.

An enhanced version of MST for families on with children on the edge of care in the US has produced improvements in terms of parental mental health, and reduced anxiety and trauma in children. However, the impact of MSFT programme may depend on the severity and complexity of the families' problems, with some studies showing more limited effectiveness (Oliver 2009; review with narrative summary).

- See: **Multi-systemic family therapy**: <http://mstservices.com/what-is-mst/treatment-model>
- Other potentially effective family-focused interventions include family-focused casework and therapeutic groups (e.g. Florida Infant Mental Health Pilot Programme,<sup>78</sup> and Parent Child Attunement Therapy<sup>79</sup> (Barlow 2006a, review of reviews).
  - **Parent Child Interaction Therapy (PCIT)** <http://www.pcit.org/what-is-pcit1.html>; **Parent-child attunement therapy** <http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1213&context=cehsdiss>
- Evidence from a small number of studies supports the Childhaven therapeutic model<sup>80</sup> for preschool children who have been physically abused and their families (Montgomery 2009, review with narrative summary).
  - See: **Childhaven** <https://childhaven.org/breaking-the-cycle/trauma-treatment>
- Two reviews of low quality support Solutions-Focused Brief Therapy (SBFT) to improve children's internalising and externalising problem behaviour (Montgomery 2009; see also systematic review without meta-analysis by Woods, 2011). However, it can be difficult to measure the effectiveness of SBFT when it is offered in conjunction with other forms of support, and the reasons for the effectiveness of SBFT with some children and families and not others, is as yet unclear (Systematic review without meta-analysis by Woods 2011).
  - See: **Solutions-focused brief therapy (SBFT)** <http://www.solutionfocused.net/what-is-solution-focused-therapy/>
- Other therapeutic approaches to work with families at the edge of care, including Functional Family Therapy (FTT) and Strengthening Families Programme 10-14 (SFP 10-14), have been tested in the US and are currently being evaluated in the UK (Dixon 2015, scoping study).
  - See: **Functional Family Therapy (FTT)** <http://www.fttlc.com/>
  - **Strengthening Families Programme** <http://www.strengtheningfamiliesprogram.org>

### iii. **Sexual abuse**

- One systematic review with meta-analysis (Macdonald 2012) recommends the use of trauma-focussed cognitive-behavioural approaches as part of a flexible, staged response for children who have experienced sexual abuse. Other forms of cognitive-behavioural

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<sup>78</sup> See: Osofsky, J., Kronenberg, M., Hammer, J.H., Lederman, C., Katz, L., Adams, S., Graham, M., & Hogan, A. (2007). The development and evaluation of the intervention model for the Florida Infant Mental Health Pilot Program. *Infant Mental Health Journal*, 28, 258–280.

<sup>79</sup> See: Dombrowski, S. C., Timmer, S. G., Blacker, D. M., & Urquiza, A. J. (2005). A Positive behavioural intervention for toddlers: Parent-Child Attunement Therapy. *Child Abuse Review*, 14, 132-151

<sup>80</sup> Moore, E., Armsden, G. & Gogerty, P. L. (1998) A twelve-year follow-up study of maltreated and at-risk children who received early therapeutic child care. *Child Maltreatment*, 3, 3-16.

therapy can also improve specific mental-health outcomes for sexually abused children with post-traumatic stress symptoms, including post-traumatic stress disorder, anxiety, depression but effect sizes are either modest or do not reach statistical significance.

- See: **trauma-focussed cognitive-behavioural therapy**  
<http://www.goodtherapy.org/learn-about-therapy/types/trauma-focused-cognitive-behavioral-therapy>

**Note:** forthcoming guidelines on child abuse and neglect by NICE (due in September 2017) advise the following:

- Sexual abuse: For boys and girls aged 8 to 17 who have been sexually abused, consider a programme such as 'Letting The Future In (LTFI).'<sup>81</sup> LTFI (i) emphasises the importance of the therapeutic relationship between the child and therapist ; (ii) 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);(iii) includes individual work with the child (up to 20 sessions, extending to 30 as needed) and (iv) involves parallel work with non-abusing parents or carers (up to 8 sessions).
  - See: <https://www.nspcc.org.uk/globalassets/documents/research-reports/letting-the-future-in-evaluation.pdf>
- For girls aged 6 to 14 who have been sexually abused and who are showing symptoms of emotional or behavioural disturbance, the recommendation is to carefully discuss with the girl, what option would suit her best: individual focused psychoanalytic therapy (up to 30 sessions) or group psychotherapeutic and psychoeducational sessions (up to 25 18 sessions). Separate sessions need to be provided for the non-offending parent or carer.

#### **iv. Emotional abuse (see also attachment-focused interventions, above)**

This section is based on data from a systematic review without meta-analysis (Barlow and Schrader McMillan, 2010), a non-systematic review (Macmillan, 2009), and an individual study by Harwin, et al (2016).

No single approach has been used to address emotional abuse, possibly because it is such a wide-ranging topic and potentially includes not only verbal aggression, instrumental use of the child, parentification, and emotional neglect of a child but also exposure to harmful environments in which there is intimate-partner violence, drug misuse or crime. Emotional abuse also includes the child's emotional needs not being met as a result of problems that the parent is experiencing, including mental health problems or chronic stress. Children may also be asymptomatic, making assessment difficult (Barlow and Schrader McMillan, 2010).

There is limited evidence regarding the effectiveness of interventions specifically designed for parents or caregivers who emotionally abuse their children with no co-occurring physical or sexual abuse or physical neglect, although some promising programmes are emerging for parents with addiction problems. (Definitions of emotional abuse include children's exposure to parental drug addiction –see Barlow and Schrader McMillan, *ibid.*)

- *Parent-focused interventions:* There is some evidence of the potential value of enhanced versions of behavioural parent training for the treatment of some forms of habitually

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<sup>81</sup> Carpenter J et al. (2016) *Letting the Future In: A therapeutic intervention for children affected by sexual abuse and their carers. An evaluation of impact and evaluation.* London: NSPCC.

abusive behaviour as part of a stepped care approach. Enhanced versions of Triple P<sup>82</sup> and Incredible Years programmes<sup>83</sup> can reduce parental depression, marital conflict, isolation and the impact of socio-economic stress. Behavioural social work involves therapeutic work with parents focused on the teaching of key parenting tasks based on the use of behavioural principles,<sup>84</sup> and there is some evidence based on a very small number of weak studies that this approach has potential in addressing issues such as negatively charged interactions.

- See: **Incredible Years:** <http://www.cebc4cw.org/program/the-incredible-years/>;  
**Triple P:** <http://www.cebc4cw.org/program/triple-p-positive-parenting-program-system/>;
  - **Behavioural social work:**  
<http://journals.sagepub.com/doi/pdf/10.1177/104973159500500406>
- *Parent- and child-focused interventions* have been tested in relation to reducing the physical abuse of children (see previous section). There is evidence to support Watch, Wait and Wonder;<sup>85</sup> Pre-school Parent Psychotherapy (PPP)<sup>86</sup>; and the Parent Child Game (PCG) in families where the difficulties are severe and/or longstanding. The focus of some of these programmes is to enable parents to recognise and reflect on their parenting behaviour and to make links between their own experiences of being parented and their parenting style in a way that encourages greater sensitivity to the child's emotional responses. There is also some evidence to support parent-child psychotherapy.<sup>87</sup>
    - See for example:
    - **Watch, Wait and Wonder;** <http://watchwaitandwonder.com/>
    - **The Parent Child Game (PCG)** <http://www.familyfocused.co.uk/pcg.html>
    - **Pre-school parent psychotherapy (PPP)** <http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed>
    - **Parent infant psychotherapy** <http://psychoanalysis.columbia.edu/patients/children-and-teens/parent-infant-psychotherapy>
  - In spite of the significant contribution of family systems theory to practice, there is surprisingly little research on systemic approaches such as Family Therapy in which emotional abuse by primary carers is the primary cause for intervention. Case studies suggest the potential of systemic approaches and this is an area on which robust research is needed.

#### v. *Children exposed to parents with impaired personality functioning*

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<sup>82</sup> Sanders MR, Pidgeon AM 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*. Vol 35(3): 513-535.

<sup>83</sup> See for example: Hughes JR and Gottlieb LN. (2004) The effects of the Webster-Stratton parenting program on maltreating families: fostering strengths. *Child Abuse Negl* 2004; 28: 1081-97.

<sup>84</sup> Iwaniec D (2007). *The emotionally abused and neglected child: identification, assessment and intervention*. Chichester, John Wiley and Sons.

<sup>85</sup> Cohen N, Muir E, Parker CJ, Brown M, Lojkasek M, Muir R, Barwick MI (1999). Watch, wait and wonder: Testing the effectiveness of a new approach to mother-infant psychotherapy. *Infant Mental Health Journal* 20(4): 429-451.

<sup>86</sup> Toth S, Maughan A, Todd Manly J, Spagnola M, Cicchetti C (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory, *Development and Psychopathology* 14: 887-908.

<sup>87</sup> Toth S, Rogosch F et al. (2006). The Efficacy of Toddler-Parent Psychotherapy to Reorganize Attachment in the Young Offspring of Mothers With Major Depressive Disorder: A Randomized Preventive T

- A parent's impaired functioning can include emotional dysregulation and an impaired capacity for self-reflection or recognising mental states in oneself and others. There is good evidence that some elements of parental impaired personality functioning can be treated with intensive therapy (Ward, 2014, review with narrative summary). Programmes such as mentalisation-based treatment,<sup>88</sup> dialectical behavioural therapy,<sup>89</sup> and schema-focussed therapy<sup>90</sup> have been shown to be effective in improving such functioning.<sup>91</sup>

See for example:

- **Mentalization based therapy** - <https://psychcentral.com/lib/mentalization-based-therapy-mbt>
- **Dialectical behavioural therapy** <http://www.goodtherapy.org/learn-about-therapy/types/dialectical-behavioral-therapy>
- **Schema-focussed therapy** [http://cognitivetherapy.me.uk/schema\\_therapy.htm](http://cognitivetherapy.me.uk/schema_therapy.htm)

#### vi. *Children exposed to parents who abuse drugs and/or alcohol*

- One systematic review (Niccols 2009), concluded that integrated programmes (i.e. those which combine a focus on substance use *and* parenting) can be effective in improving outcomes for children. Improvements in parenting were associated with the use of attachment-based parenting interventions, children residing in the treatment facility, and improvements in maternal mental health. However, caution is needed in relation to some attachment-based interventions because intervention gains were not only lost to follow-up but outcomes for some measures were worse than for control groups.<sup>92</sup> Further research is also needed on integrated *residential* programmes.
- Three evaluations of pilot sites in the UK found promising results to support Family Drug and Alcohol Court programmes<sup>93</sup> for both fathers and mothers on a number of outcomes, including parental drug cessation and parenting. A longitudinal study by Harwin et al (2016) found significant positive results favouring the intervention on the following outcomes: mothers reunited with their children at the end of proceedings (37% v 25%); no disruption to family stability (a combination of relapse, permanent placement change or return to court) over a 3 year period after proceedings ended (51% v 22%). Compared to mothers going through the ordinary family court, a significantly higher proportion of mothers going through FDAC: stopped misusing substances at the end of proceedings (46% v 30%) and were more likely to sustain substance misuse cessation during the 5 year period after care proceedings ended (58% v 24%). Sample size was small and larger studies are needed. However, as Ward (2014) observes, when combined with a package of timely, co-ordinated interventions from a range of professionals, the authority provided by the courts can have a valuable role in motivating parents to change (Ward, 2014). It also appears more effective in engaging fathers than standard proceedings.

<sup>88</sup> Bateman, A. W., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry, 9*(1), 11-15.

<sup>89</sup> Linehan, M.M (2000) The empirical basis of dialectical behavior therapy: Development of new treatments *versus* evaluation of existing treatments. *Clinical Psychology: Science and Practice, 7*:1, 113-119; Linehan, M.M. *et al.* (2002) 'Dialectical behavior therapy *versus* comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder.' *Drug and Alcohol Dependence, 67*,13-26.

<sup>90</sup> Giesen-Bloo, J. *et al.*. (2006) 'Outpatient psychotherapy for borderline personality disorder: randomized trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy.' *Archives of General Psychiatry* 63: 6, 649-658.

<sup>91</sup> See also NICE guidelines on treatment of mental health problems in Reference section, below.

<sup>92</sup> See for example: Luthar S, Suchman ES, Altomare M (2007) Relational psychotherapy mother's group: A randomized clinical trial for substance abusing mothers. *Dev Psychopathol* 19:243-261.

<sup>93</sup> See for example: Harwin, J., Alrouh, B., Ryan, M. and Tunnard, J. (2014) *Changing Lifestyles, Keeping Children Safe: an evaluation of the first Family Drug and Alcohol Court (FDAC) in care proceedings*. London: Brunel University.

- See: **Family Drug and Alcohol Court programmes**  
<http://www.coram.org.uk/supporting-parents/family-drug-and-alcohol-court>
- One RCT supports the use of the Parents under Pressure (PUP) programme with substance dependent parents in terms of reduced substance use, less parenting stress, and improved child behaviour.<sup>94</sup> (in Barlow and Schrader McMillan, 2010; Ward, 2014, Macmillan, 2009). Two further RCTs are underway in the UK at the time of writing.
  - See: **Parents Under Pressure (PUP)** <http://www.pupprogram.net.au>
- One RCT <sup>95</sup>evaluated the effectiveness of a *mentalisation based programme* known as the Mothers and Toddlers Programme (MTP), which combines individual therapy with standard outpatient substance abuse treatment programmes. The trial found moderate improvements favouring the intervention although some effects were reduced or not sustained at follow up.
  - See: a more detailed description at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928150/>

## **vii. Domestic violence**

This section draws on a review of reviews/systematic review by the British Columbia Centre of Excellence for Women’s Health (BCCEWH, 2013). This document, commissioned by NICE, was the most recent and comprehensive review.<sup>96</sup> Adjunctive information was obtained from other sources.

The evidence points to the need to integrate empirically validated substance abuse, couples, and trauma-focused interventions into IPV treatments. However, considerably more work is needed to develop effective interventions, in particular with respect to perpetrators (BCCEWH, 2013).

### **a. Work with victim-survivors of DV**

Unless otherwise specified, the following is a brief summary of key findings from the NICE guidelines (BCCEWH, 2013), which are the most comprehensive recent synthesis of the evidence.

Interventions for victims of IPV are provided in a range of settings including shelters, prenatal clinics, or the community, with police–social service outreach and advocacy.

- There is moderate evidence from 10 studies that advocacy services can improve women’s access to community resources, reduce rates of IPV, improve safety, decrease depression, reduce various stressors, and improve parenting stress and children’s well-being. Advocacy interventions are those that inform, guide and help victims of DV to access a range of services and supports, and ensure their rights and entitlements are achieved. Interventions included: community based mentorship, home visitation advocacy services, Independent Domestic Violence Advisory Services (IDVAs), emergency department advocacy services, advocacy services for rural women, shelter and post-shelter advocacy services, and a 24 hour helpline services. However, cumulative evidence on the *long term* effects finds very high levels of recidivism (i.e. re-exposure to partner violence).

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<sup>94</sup> See for example, Dawe, S. and Harnett, P. H. (2007) ‘Improving family functioning in methadone maintained families: results from a randomised controlled trial.’ *Journal of Substance Abuse Treatment* 32, 381-390. Two further RCTs are currently underway in the UK.

<sup>95</sup> Suchman, N *et al* (2011). The mothers and toddlers program, an attachment-based parenting intervention for substance- using women: Results at 6-week follow-up in a randomized clinical pilot. *Infant mental health Journal*, 32, 427–449.

<sup>96</sup> Available on: <http://www.domesticviolenceresearch.org/17-full-pask-manuscripts-and-tables-of-summarized-studies/> (Accessed 12.09.16)

- There is moderate evidence that skill-building (teaching, training, experiential or group learning) on a range of topics with victims of partner violence is associated with improvements in coping, well-being, decision-making abilities, and safety. Interventions varied widely in terms of the skills taught: coping skills, safety planning and conflict resolution skills, knowledge of sexual/reproductive coercion, decision-making and danger-assessment skills, economic education, and sleep training.
- There is moderate evidence that counselling interventions may improve: PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, re-occurrence of violence, birth outcomes for pregnant women, motivational level, readiness to change, and/ or forgiveness. Counselling/ brief interventions promote a range of outcomes, such as reducing depression and increasing empowerment among those who have experienced DV, through interventions based on brief educational, cognitive-behavioural, and motivational interviewing approaches. While the majority of interventions reported improvements on the various outcomes measured, some reported only modest improvements or improvements on some but not all measures.
- There is moderate evidence from eight studies that therapy interventions may be effective in improving PTSD symptoms, depression, trauma symptoms, psychological and social outcomes, parenting/ family-related outcomes and in some cases may reduce likelihood of future IPV or re-abuse (although again findings relating to revictimisation are mixed). Interventions included: cognitive processing and written account therapies, cognitive behavioural therapy, emotion- and goal-focused group therapy, psychosocial group therapy, dialectical behavioural therapy and holistic group therapy. Most studies have involved low-income women. All studies reported improvements on the various outcomes measured although the strength of effectiveness varies.
  - For **further description of interventions for victim survivors of DV see:** pp 109-141 of the BCCEHW 2013 review. <https://www.nice.org.uk/guidance/ph50/resources/review-of-interventions-to-identify-prevent-reduce-and-respond-to-domestic-violence2>. See also: See also: **Advocacy services (IDVAs)** <http://www.refuge.org.uk/what-we-do/our-services/independent-domestic-violence-advocacy/>

## b. Work with perpetrators of DV

*Note: Aspects of personality functioning associated with increased risk of violence perpetration include emotional dysregulation, impaired capacity for mentalisation – see previous section for potential therapeutic approaches; see also review level evidence on the Partner Abuse State of Knowledge database.<sup>97</sup>*

### *Batterer Intervention Programmes (BIPs) and Cognitive-Behavioural Therapy (CBT)*

- Unless otherwise specified, the following primarily summarises key findings from BCCEHW (2013). Several studies in this review included female batterers/abusers, but the majority addressed interventions for heterosexual males. Studies varied in whether participants were court-mandated, non-mandated, or both.
- Short duration group approaches (16 weeks or less) included: family of origin group therapy, a solution- and goal-focused group treatment programme, CBT, unstructured supportive group therapy, group counselling, and group sessions based on the Duluth

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<sup>97</sup> <http://www.domesticviolenceresearch.org/>

model. On the whole evidence shows greater improvement in terms of perpetrators beliefs and attitudes than recidivism.

- Long duration approaches (over 16 weeks) included: CBT programs, psycho-educational components, abuser schema therapy, Duluth-based group therapy. As with short term interventions, evidence of effectiveness was inconsistent, with most studies demonstrating improvements (on measures such as: communication, motivation to change, attitudes towards violence, conflict management skills, etc.). Dropout is a significant problem in most treatment studies for perpetrators and participation may be enhanced by incorporating Motivational Interviewing (MI) techniques.
- Review level evidence on Batterer Intervention Programmes (BIPs) based on psychoeducational/Duluth models has consistently shown low effect sizes in terms of perpetrator behaviour change. Effects are stronger on changes in beliefs and attitudes associated with violence than on recidivism. A recent exception to these findings is presented by the Mirabal project, a five year longitudinal study undertaken in the UK, on Respect-accredited Domestic Violence Perpetrator Programmes (DVPPs).<sup>98</sup> With regards to the intervention group only, positive findings were reported for women's perceived sense of safety (i.e. reduction of exposure to violence), with varying trends in the desired direction on other outcomes. However no difference was found between the intervention and control group. Control group data was excluded from the final analysis and report, a methodological weakness that limits the conclusions that can be drawn from this study.
- An evaluation of a fathering programme for partner-violent men - Caring Dads, Safer Children (CDSC) - found evidence of sustained change among a proportion of fathers who completed the programme, as borne out by self report and partner report at follow up. However, the programme had high levels of attrition (49%) and even among some fathers who completed the programme change was insufficient to cease monitoring contact with their families. In such circumstances, feedback to referrers from CDSC workers informed decision making about the father's access to his children (McConnell, 2016)<sup>99</sup>
- Individual (one-to-one) interventions include: case management, an individual level intervention combined with community outreach services, solution focused therapy, educational interventions, and motivational interviewing. As with group work, individual interventions appeared to have a greater effect on attitudinal outcomes than recidivism/violence outcomes (which, when measured improved in some but not all studies)., There is also evidence to support Motivational Interviewing in terms of increased adherence to treatment.

Stover (2009: 231) concludes that 'much more attention needs to be paid to the question of, "Which treatment for whom?" ' Assessment of individual treatment needs would allow for a better fit between individual perpetrators and /or victims and their treatment.

NICE (2014) guidelines recommend commissioning and evaluating new forms of treatment for DV perpetration.

- For **more detailed descriptions of interventions for perpetrators see:** pp 143-171 of the BCCEHW 2013 review. <https://www.nice.org.uk/guidance/ph50/resources/review-of-interventions-to-identify-prevent-reduce-and-respond-to-domestic-violence2>. **For an example and brief outline of treatments for DV perpetrators in the UK, see:** [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/225199/glossary-programmes.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/225199/glossary-programmes.pdf).

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<sup>98</sup> Kelly, L. and Westmarland, N. (2015) *Domestic Violence Perpetrator Programmes: Steps Towards Change. Project Mirabal Final Report*. London and Durham: London Metropolitan University and Durham University.

<sup>99</sup> McConnell et al, (2016) *Caring Dads: Safer Children: Learning from delivering the programme*. London: NSPCC.

Domestic violence and abuse organisations have responded to the need for more work to develop effective interventions, particularly with respect to perpetrators. There is a great deal of innovation in this area and new interventions are being developed and tested which may improve our understanding of what is effective. New interventions for families currently piloted in the UK (with evaluation underway) include the NSPCC's Steps to Safety Programme and the Stephanou Foundation's Health Relationships, Healthy Baby model.

- For Health Relationships: Healthy Baby, see: <http://www.hra.nhs.uk/news/research-summaries/health-relationships-healthy-baby-programme/>
- For Steps to Safety, see: <https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/steps-to-safety/>

### c. Couples work with and without treatment for substance abuse

The BCCEWH (2013) review found preliminary evidence to support the efficacy of behavioural couples therapy (BCT) adapted to couples in situations where DV is compounded by alcohol and/or drug abuse. Although the quality of studies is weak, findings to date suggest a reduction in aggression outcomes, improvements in relationship skills, satisfaction and conflict. All forms of couples work in the context of DV require careful screening for risk.

- For **descriptions of interventions with couples see:** pp 176-183 of the BCCEHW 2013 review. <https://www.nice.org.uk/guidance/ph50/resources/review-of-interventions-to-identify-prevent-reduce-and-respond-to-domestic-violence2>. **See also: behavioural couples therapy (BCT)** <http://www.behaviouralcouplestherapy.com/what-is-bct/>

### d. Children exposed to DV

The following is a summary of key findings from a single review included in BCCEWH, (2013). All studies involved children alone, or victimised mothers and children.

Several forms of treatment have shown promising effectiveness data, with conjoint treatment of mother and child being the most effective. These interventions have been evaluated primarily in families where a mother and child are no longer living with the perpetrators, with maternal substance abuse as a criterion for exclusion.<sup>100</sup> This limits the generalizability of findings in other contexts.

- For **further description of interventions with children see:** pp 219 – 237 of the BCCEHW 2013 review. <https://www.nice.org.uk/guidance/ph50/resources/review-of-interventions-to-identify-prevent-reduce-and-respond-to-domestic-violence2>.

#### *Therapeutic interventions:*

- Therapeutic treatment that involves mothers and children together (no included studies involved victimised fathers) appear to be more effective than community case management or child-only treatment, on a range of outcomes for both mother and child. Intervention approaches included: mother-child psychotherapy, shelter-based parenting intervention combined with play sessions for children, parent-child interaction therapy (including mother-child play, teaching of praise and discipline techniques), and an experiential, activity-based and interactive therapy.
- One study of children who experienced sexual abuse and domestic violence found that trauma-focused CBT was superior to child-centred therapy in decreasing post-traumatic stress disorder symptoms (19% versus 46%).
  - **See also:** the following are *examples* of approaches to work with children, outlined above. **Child parent psychotherapy (adapted for children exposed to DV)** – includes modified forms of **Parent Child Interaction Therapy** <http://www.pcit.org/what-is-pcit1.html>;

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<sup>100</sup> Stover C et al. (2009) Interventions for intimate partner violence: review and implications for evidence-based practice. *Professional Psychology, Research and Practice* 40(3): 223-233.

### **Child psychotherapy: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

<http://www.goodtherapy.org/learn-about-therapy/types/trauma-focused-cognitive-behavioral-therapy>

#### *Expressive, play and other forms of therapy*

- There is very little robust evidence concerning the effectiveness of approaches such as play therapy, expressive writing therapy, and equine assisted psychotherapy in treatment of children exposed to DV. Play therapy and equine therapy both demonstrated some improvements with diverse groups of children in behaviour, aggression and self-esteem, but the studies on which this is based are very weak.
  - **See:** for example, <http://www.counselling-directory.org.uk/equine-assisted-therapy.html>; <http://www.leapequine.com/>
  - **Play therapy:** see for example, [http://playtherapy.org.uk/Expressive writing therapy](http://playtherapy.org.uk/Expressive%20writing%20therapy): see for example: [http://www.writejunior.nl/persmap/03 Wiley InterScience.pdf](http://www.writejunior.nl/persmap/03%20Wiley%20InterScience.pdf)
  - **Expressive Art therapy:** see for example: <http://www.goodtherapy.org/learn-about-therapy/types/expressive-arts-therapy>

#### *Psycho-educational interventions*

- There is inconsistent evidence with respect to psycho-educational interventions aimed at strengthening mothers and children's skills coping skills, increasing knowledge of DV and improving children's behaviour and mothers' parenting skills. However, there is moderate evidence that psycho-educational interventions aimed at children are effective in improving children's coping skills, behaviour, emotional regulation, conflict resolution skills, and knowledge about violence.
  - **See:** the following are *examples* of approaches to work with children, outlined above.  
**Psychoeducational programmes – mothers and children:** an example is **Kids and Moms Empowerment** <http://www.cebc4cw.org/program/kids-club-moms-empowerment/detailed>

#### *Multicomponent interventions*

- Moderate evidence that multi-component interventions, such as community-based service planning, nurse case management, and non-parental child care for disadvantaged families are effective in reducing the trauma symptoms and stress in both children and mothers and in improving problematic child behaviours.

### **viii. Neglect**

Defining child neglect has been difficult, and this has led to challenges in measuring neglect and associated outcomes. There is a dearth of studies that report specifically on neglect, defined as 'an act of omission rather than commission that occurs when children's basic needs are not adequately met'. The following outcomes are reported in one systematic review with narrative synthesis of five included studies (Allin, 2005).

- There is some support for the effectiveness of resilient peer treatment and imaginative play training, for multi-systemic therapy, and for a specific therapeutic day treatment program neglected children's self-concept, behaviour, social and emotional functioning.<sup>101</sup>
- Although school-based interventions and play therapy can lead to improved outcomes for the child, the fundamental root of the problem – the child's experience of neglect by a

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<sup>101</sup> These studies were included in an earlier systematic review on treatment of neglect by some of the same authors. Allin H et al, (2005) Treatment of Child Neglect: A Systematic Review *Can J Psychiatry*, 50:8, 497 – 504.

primary carer – needs to be addressed (Allin, 2005). There is evidence to support multisystemic therapy (MST) to improve parent-child interaction and child outcomes, but findings elsewhere are not consistent.

See for example:

- **Classroom based resilient peer training for traumatic stress** - <http://effectivechildtherapy.org/content/other-treatments>;
- **Play therapy** - [https://www.jfhc.co.uk/play\\_therapy\\_as\\_a\\_mental\\_health\\_intervention\\_for\\_children\\_and\\_adolescents\\_20942.aspx](https://www.jfhc.co.uk/play_therapy_as_a_mental_health_intervention_for_children_and_adolescents_20942.aspx);
- **Therapeutic day training** - <http://youthfortomorrow.org/Therapeutic-Day-Treatment>
- **Multisystemic therapy**: <http://eif.org.uk/wp-content/uploads/2014/07/MST-CAN.pdf>

### ***ix. Interventions that focus on fathers***

There is robust very limited research on the impact of interventions on fathers of children on the edge of care.<sup>102</sup>

One systematic review (Smith 2012) reported that programmes that are intended for either or both parents do not separate results for mothers and fathers so their effectiveness in enabling change in fathers specifically is unclear; the review could not undertake meta-analysis.

Two studies of interventions that provided data that is specific to fathers were identified. There is evidence based on one study to support Dads Actively Developing Families ('DADS') for men in prison. This reported significant difference in terms of aspects of parenting, including permitting children's self-expression, avoidance of harsh punishment and no physical punishment. No impact was found on other measures. Men in the video training group had more significant pre-post changes compared to men in the in-person training group.<sup>103</sup> Mixed evidence was found for Hawaii Healthy Start, a targeted home visiting programme that included fathers who were violent and fathers who were not. For example, it found no significant impact on parenting of fathers who were violent at baseline but benefits for fathers who were not violent.<sup>104</sup>

○ See: **Project Dad**: <http://www.peopleforpeople.org/projectdad/program-overview.html>

- Although there is evidence to support the use of other programmes included in the review by Smith (2012), the data for men and women are not disaggregated, making it difficult to know enough about fathers' experiences of these interventions and their effectiveness with fathers. Studies on the Hawaii Home Visiting programme (Duggan 2004) shows that fathers who are in employment were less likely to engage with the service or continue in it. This raises practical questions about the times and places where programmes are delivered.

### ***x. Intensive family preservation programmes***

- Intensive family preservation programmes designed along the lines of 'Homebuilders' in the US can be effective in providing respite/ improving family functioning when a child is on the edge of care because a family is undergoing a *temporary* crisis (systematic review

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<sup>102</sup> There are many programmes and interventions with a focus on fatherhood, for example, for men in prisons, but few have been well evaluated to date. See for example, <http://archive.vera.org/sites/default/files/resources/downloads/fathers.pdf> (Accessed 02/02/17)

<sup>103</sup> Cornille TA et al (2005). *DADS Family Project: An experiential group approach to support fathers in their relationship with their children*. *Social Work with Groups: A Journal of Community and Clinical Practice* 28(2): 41–57.

<sup>104</sup> Duggan A, et al. (2004). *Evaluating a statewide home visiting programme to prevent child abuse in at-risk families of newborns: father's participation and outcomes*. *Child Maltreatment* 9(1): 3–17.

with meta-analysis Al (2012). The intervention is least effective with families with patterns of chronic abuse and neglect.

- A non-systematic review of the literature (Thoburn *et al* 2009) reports some evidence, from a series of studies in the US and UK that family preservation services are more effective in preventing long-term family breakdown (i) if they are preceded and/or followed by targeted lower-intensity or episodic services, or (ii) if the same service has 'permeable boundaries' that allow parents to re-enter the service of their own volition if problems reoccur again.<sup>105</sup>
- Intensive Family Preservation Services (IFPS) have also been implemented and evaluated in the UK. For instance, Option 2 is a Welsh intensive family preservation service based on the US Homebuilders model. It is aimed at reducing the need for children from families experiencing parental substance misuse, to enter care. A nonrandomized trial of Option 2 compared the outcomes for 278 children receiving the service with those for 89 children in a waiting list control. The average follow-up period was 3.5 years. As in the US studies, the evaluation found that participation in the Option 2 service did not reduce the likelihood of entering care (40% of the children in Option 2 entered care *versus* 41% in the comparison group) but that children in the Option 2 group entered care on average 117 days later than those in the comparison group; they spent less time in care (766 days vs. 958 days) and were more likely to return home (68% of Option 2 children were at home at follow up compared with 56% of the comparison group) (Forrester *et al.*, 2012).<sup>106</sup>
  - See for example **Homebuilders Option 2:**  
<http://gov.wales/topics/health/socialcare/working/ifst/ifsspublications/option2model/?lang=en>

## xii. *Older maltreated children with trauma symptoms*

- One non-systematic review (Macmillan 2009) assessed the effectiveness of interventions in reducing psychological harm in children and adolescents with signs of trauma, and suggests that most research involves sexually abused children or adolescents, with limited work on trauma resulting from physical abuse or exposure to domestic violence.

The evidence available indicates that parent-child psychotherapy, or trauma-focused cognitive therapy for both the child and parent, may improve parental sensitivity or attachment security in children and in young people with signs of trauma as a consequence of maltreatment.

- *For older children/adolescents* NICE (2015, review of reviews) recommends the following evidence-based treatments: cognitive behavioural therapy (CBT), interpersonal therapy, eye movement desensitisation and reprocessing, dialectical behaviour therapy, cognitive analytic therapy and family therapy.
  - See for example: **Cognitive behavioural therapy (CBT)** - <http://effectivechildtherapy.org/content/what-cbt>; **Interpersonal therapy** - <http://www.cebc4cw.org/program/interpersonal-psychotherapy-for-depressed-adolescents/detailed>; **Eye movement desensitisation and reprocessing**, - <http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/detailed>; **Dialectical behaviour therapy** - <https://childmind.org/article/dbt-dialectical-behavior-therapy>; **Cognitive analytic therapy** - <http://www.acat.me.uk/page/cat+with+adolescents>; <http://www.acat.me.uk/factsheets/cat-faqs-for-private-providers.pdf>; **Family therapy** - <http://www.aft.org.uk/consider/view/family-therapy.html>

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<sup>105</sup> Schuerman, J. R., Rzepnicki, T. L. and Littell, J. H. (1994) *Putting families first: an experiment in family preservation*, New York: Aldine de Gruyter; Brandon, M. and Connolly, J. (2006) 'Are intensive family preservation services useful? A UK study', *Journal of Family Preservation*, 9, 56–69.

<sup>106</sup> Forrester, D. and Harwin, J. (2008) 'Parental substance misuse and child welfare: outcomes for children two years after referral.' *British Journal of Social Work* 38, 8, 1518–1535.

### ***xii. Short stay residential treatment for young people ‘on the edge of care’***

A scoping study on the effectiveness of short-stay residential care for adolescents on the edge of care found little *published* evidence, but new primary data about a number of models operating across the UK (Dixon et al. 2015, scoping study).<sup>107</sup>

- This study reports that respite that combines direct work with young people *and* support for their families can better meet the needs of *some* older adolescents and/or those with more challenging behaviours (compared with foster or kinship care).
- There is some evidence that it can help reduce entry to care by improving young people’s relationships with their families, and their families’ ability to care for them; support planned and appropriate entry to care for those young people who cannot stay with their families; and reduce costs.
- *The following conditions are identified as contributing to success:* The need for very careful assessment; good staff training; regular risk assessments; appropriate matching of young people in the home, under regular review; tailored, needs-led packages of support; effective multi-agency working with firm agreements in place; agreements made with families and young people.

However, there are also risks associated with the model, including pressure on staff, the possibility of young people negatively affecting each other, and that care-preventative approaches might prove ineffective or indeed detrimental if they delay entry to care.

- See: for a summary of Dixon’s (2015) findings on **short term residential care**, see <https://www.actionforchildren.org.uk/media/5147/edge-of-care-summary-design-v4.pdf>

#### **Summary**

In cases where parents are facing complex, multi-layered problems, an integrated package of support is likely to be required; this must be tailored to meet the needs of each member of the family following careful assessment (Barlow, 2006a, review of reviews; Ward, 2014, systematic review with narrative summary). The package needs to be delivered within an acceptable time frame and with the child as the central focus of attention.

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<sup>107</sup> Dixon, J. et al. (2015) *Supporting Adolescents on the Edge of Care: The role of short term stays in residential care*. London: Action for Children. Available at: <https://www.actionforchildren.org.uk/media/5065/edge-of-care-report.pdf>

### 3.6 Targeted Youth Services

A significant minority of teenagers have entrenched problems that can put them on the edge of care. Authoritative, nurturing parenting remains a protective factor even for adolescents in poor and risky environments.<sup>108</sup> Research on the relationship between parenting and adolescent outcomes has generally found that an authoritative, nurturing parenting style is a consistent predictor of positive adolescent outcomes.<sup>109</sup> Although interventions in the early years are focused primarily on parenting, as they grow older young people with difficulties that are often related to problems and losses within their family, require a wider range of support within school, community, and other settings, to avoid difficulties spiralling out of control.<sup>110</sup>

Targeted Youth Services (TYS) prioritised older children and adolescents (11 – 17) who experience a combination of the following: chronic absence or exclusion from school; behavioural problems; poor emotional, social or coping skills; poor mental health; low self-efficacy; poor aspiration; engagement in risky behaviours; family and/or friends engaged in crime or gangs, who condone high risk activities; poor family support, family conflict or entrenched parental problems, including parental drug or alcohol abuse; poor support networks; living in a deprived neighbourhood; poverty. It should help ensure the needs of these young people are identified, met, and dovetail with (and, as specialist or statutory provision they may be receiving or may need. Whenever possible, YYS should help young people settle back and do well in mainstream universal services as soon as possible.

#### Sources:

- Systematic review summarised in narrative form: O'Mara (2010)
- Non-systematic review: Thoburn (2009).

#### 3.6.1 Referrals

Schools are the main site for the uptake and recruitment of young people into YYS interventions; agencies should work closely with schools especially to access hard to reach populations, e.g. excluded children.

- Good information on vulnerable young people needs to be gathered, recorded and shared by schools in order to support integration and the referral process.
- More consistent definitions of 'at risk' and 'vulnerable' are needed to ensure right match with services (O'Mara 2010).

Thoburn's (2009) review of the literature concludes that teenagers exposed to neglectful parenting are less likely to be referred (and less likely to refer themselves) to a child protection service. Outreach youth workers are therefore well placed to help and encourage teenagers to

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<sup>108</sup> See for example, Hoeve M et al (2009) The Relationship Between Parenting and Delinquency: A Meta-analysis. *Abnorm Child Psychol.* 37(6): 749–775 on the relationship between parenting warmth, engagement, father involvement, parenting style and delinquency.

<sup>109</sup> Hoskins, D. (2014) Consequences of Parenting on Adolescent Outcomes. *Societies*, 4, 506–531. There is some cultural variance in the relationship between parenting style and adolescent outcomes.

<sup>110</sup> See for example, Hoeve M et al (2009) The Relationship between Parenting and Delinquency: A Meta-analysis. *Abnorm Child Psychol.* 37(6): 749–775 on the relationship between parenting warmth, engagement, father involvement, parenting style and delinquency.

seek assistance, when the opportunity arises; teenagers will sometimes hint at abuse and neglect and are of course, often drawn to risky behaviour.

### 3.6.2 Effective methods of working

O'Mara (2010) produces examples of effectiveness of group-based and one-to-one youth work in:

- Reducing teenage pregnancies and promoting positive behaviours.
- Reducing emotional and behavioural problems, including delinquency/offending, school exclusion and truancy.
- Increasing emotional wellbeing and confidence
- Increasing participation in education.
- Benefits can go beyond intended consequences e.g. on family relationships and improving parental engagement.

#### Summary

TYS programmes are aimed at vulnerable youth, such as those who are not attending school or who are using drugs, engaging in risky sexual behaviours, having problems at home or exhibiting anti-social behaviours. In many of the studies, the youth had multiple needs; this can make helping them particularly difficult. TYS programmes frequently improve outcomes for vulnerable youth.

The evidence presented in this review shows that some TYS interventions in the areas of pregnancy prevention were effective across a range of desired outcomes, but also some unintended positive consequences including improvements in young people's confidence and behaviours, family relationships, in addition to benefits for parents and carers.

The most commonly identified elements of success for YTS include: a person-focused approach, communication, adequate resources, longer duration and higher intensity programmes. Critical to the success of most interventions is an empowered, well-trained workforce, collaborative multi-agency relationships, and effective evaluation and monitoring of the services. Successful TYS interventions build and maintain strong relationships on three levels: (a) between agencies, (b) with local communities and (c) at the one-to-one level with young people involved in TYS. Findings indicate the importance of reducing stigma, keeping interventions in an environment where the participant feels at home and focusing on one-to-one relationships. Above all, young peoples' input and participation is essential for successful design.

### 3.7 Cost Benefit Analysis

This section draws primarily on work cost benefit analysis undertaken by the Dartington Social Research Unit.<sup>111</sup> This, in turn partly draws on work by the Washington State Institute for Public Policy, which analyses the effects of child abuse and neglect on longer-term outcomes and the estimated cost of these effects. Although reviews by Axford et al (2015, 2016) are of good quality, the evidence is limited, particularly in the case of work with children and families on the ‘edge of care’. It is intended to provide an overview of cost benefit analysis and is not a comprehensive review.

#### Sources:

Reviews of reviews: Axford et al. 2015, Axford et al. 2016, NICE (2015).

Reviews with narrative summary: Ward (2014)

Systematic review without meta-analysis: O’Mara (2014)

#### 3.7.1 The relationship between short-term intervention effects and long-term outcomes<sup>112</sup>

Analyses by the Washington State Institute for Public Policy (WSIPP) (2015) seek to establish causal links between short-term outcomes that are measured in trials and longer-term outcomes that have economic implications. The following causal links have been identified for the 38 studies that have met WSIPP’s inclusion criteria.

**Table 1 Causal links between child abuse and neglect and long-term outcomes**

Predictor	Long-term outcome	Number of studies	Effect Size	Standard Error
Child abuse and neglect	Employment	3	-0.26	0.09
	Years of education	1	-0.24	0.10
	Depression	8	0.23	0.06
	Anxiety	3	0.33	0.17
	Alcohol (disordered use)	6	0.17	0.05
	Obesity	5	0.04	0.04
	Illicit drugs (disordered use)	6	0.27	0.07
	PTSD	1	0.84	0.20
	Test scores	3	-0.27	0.07
	School completion	6	-0.42	0.07
	Disruptive behaviour	1	0.46	0.39
	Special education	1	0.39	0.04
	Tobacco (regular use)	1	0.39	0.12
Crime	11	0.54	0.07	

Among other outcomes, longitudinal studies establish that (i) child maltreatment is associated with mental health disorders in adulthood, providing evidence that preventing maltreatment or the recurrence of maltreatment has implications for wellbeing over the life course (Scott et al,

<sup>111</sup> Many thanks again to colleagues at the Dartington Social Research Unit for sharing their work on cost-benefit analysis.

<sup>112</sup> “WSIPP uses very strict criteria to determine which studies can be included. In particular, there needs to be sufficient confidence that the study is establishing causality between the short-term outcome and the longer-term outcome that it measures. This requires the study to clearly establish temporal ordering (one outcome, such as conduct problems, should precede another outcome, such as crime) and account for other factors that could also influence the outcome (such as family income).” (Axford et al., 2015: 2008) See: [http://dartington.org.uk/inc/uploads/Healthy\\_Child\\_Programme\\_0-5\\_Rapid\\_Review\\_\(2015\).pdf](http://dartington.org.uk/inc/uploads/Healthy_Child_Programme_0-5_Rapid_Review_(2015).pdf)

2010).<sup>113</sup> (ii) Child maltreatment impacts on school completion, which has implications for future economic outcomes such as further education, employment and earnings (Currie and Spatz Widom 2010).<sup>114</sup>

Maltreatment also has other effects on health outcomes through the life course.<sup>115</sup> For instance, a study based on the British Birth Cohort (Power et al., 2015) found a relationship between maltreatment and body mass index (BMI) or obesity, although this varied by type of maltreatment and by age: the association were was found to be weak or not present in childhood, but stronger associations as respondents grew older.<sup>116</sup> This provides a good example of an important consequence of child maltreatment that might not be discovered using concurrent assessments of outcomes, but that emerges with age.

NICE (2015) summarised the costs of looking after maltreated children. In England gross expenditure on looked-after children was estimated to be £2.5 billion in 2013/14. The majority of this was on foster care services (55% of expenditure, around £1.4 billion, caring for 51,340 children and young people), and children's homes (36% of expenditure, around £0.9 billion, caring for 6,360 children and young people).<sup>117</sup> The average weekly social services cost per child who experienced abuse/neglect is £163 if supported in their families or independently, and £756 if looked after.<sup>118</sup> Estimates of the average social care cost per looked-after child range from £33,634 a year for children with no additional support needs to £109,178 for those with complex emotional or behavioural needs.

NICE guidelines estimated that video feedback is the most cost-effective option for children on the edge of care. However, NICE recommends that since treatment options are very limited for this population and if parents decline the offer of a video feedback programme, parental sensitivity and behaviour training should be an option. According to the guideline economic analysis, parental sensitivity and behaviour training resulted in a cost per QALY that was below the NICE upper cost-effectiveness threshold of £30,000 per QALY. But since costs associated with attachment difficulties in children (such as costs incurred by healthcare professional contacts, need for special education, placements, offending) were not taken into account in the guideline economic model, it is likely that the cost effectiveness of all interventions was underestimated (including parental sensitivity and behaviour training). As a result, there is a high potential that parental sensitivity and behaviour training under different plausible scenarios could result in a cost per QALY that is below NICE's lower cost-effectiveness threshold.

### 3.7.2 Monetary benefits deriving from short-term outcomes

The Dartington Social Research Unit (DSRU) has developed a UK version of the WSIPP cost-benefit model to conduct analyses in British pounds for the UK context (Little et al., 2013). The overall aim is to estimate how much a change in outcomes (e.g. reduction in early conduct problems) is worth to the public sector, children receiving the intervention, and others in society respectively. The effect sizes come from analyses conducted by WSIPP (Lee et al., 2012).

The monetary benefits presented are a combination of those that would go to the participants themselves, those that would go to the public purse, and those that would apply to the wider

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<sup>113</sup> Scott KM, Smith DR, Ellis PM. (2010) Prospectively Ascertained Child Maltreatment and Its Association with DSM-IV Mental Disorders in Young Adults. *Arch Gen Psychiatry*. 67(7):712–719.

<sup>114</sup> Currie J and Spatz Widom C (2010) Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being. *Child Maltreat*. 15(2): 111–120.

<sup>115</sup> van der Kolk BA. (2005) Developmental trauma disorder. *Psychiatric Annals*, 35, 401–408.

<sup>116</sup> Power, c. et al. (2015) Childhood Maltreatment and BMI Trajectories to Mid-Adult Life: Follow-Up to Age 50y in a British Birth Cohort. *PLoS One*, 10 (3), Article e0119985. Available online: [10.1371/journal.pone.0119985](https://doi.org/10.1371/journal.pone.0119985) (Accessed 02/09/2016)

<sup>117</sup> Harker R and Heath S. (2014) *Children in Care in England: statistics*. Report SN/SG/4470. House of Commons Library.

<sup>118</sup> Curtis L. (2014) *Unit Costs of Health and Social Care 2014*. Canterbury: Personal Social Services Research Unit.

society (such as potential victims of crime). The taxpayer benefits primarily consist of the marginal costs saved by reduced demand on public services. For example, in the case of crime, the costs are derived from changes in costs to police, courts, youth justice and criminal justice systems due to changes in the volume of criminal convictions. The website (*unavailable, 2018*) provides a more detailed breakdown of these benefits for each programme. The DSRU cost-benefit model cannot yet monetise outcomes such as reduced domestic or dating violence, reduced sexual exploitation, or reduced gang violence.

Two systematic reviews (Axford et al., 2015, 2016) present results obtained using the DSRU cost-benefit model. The first review (Axford 2015) provides cost benefit analysis for interventions for families with children in the 0- 5 age range. The second review and the second (Axford 2016) for children and young people those aged 5 – 19. Three examples from second review are relevant as they apply to families where children may be at risk of out of home placements.

### **i. Intensive Family Preservation Services (Homebuilders)**

Intensive Family Preservation Services (IPFS such as Homebuilders) provide in-home crisis intervention, counselling, and life-skills education for families with children (aged birth to 17) at imminent risk of being placed into care. IPFS emphasise contact with the family within 24 hours of the crisis and aim to prevent the removal of a child from his or her biological family (or to promote his or her return home) by improving family functioning. Services are time-limited and families receive an average of 40 to 50 hours of direct service across 4 weeks. The programme is facilitated by trained therapists who are available 24 hours a day, seven days a week.

#### ***Short-term outcomes and lifetime monetary benefits by programme***

<b>Short-term outcome</b>	<b>Effect Size</b>	<b>Standard Error</b>	<b>Long-term outcome</b>	<b>Benefit</b>
Child abuse and neglect	-0.23	0.11	Crime	£69
			Social Services	£232
			Special Education	£39
			Health care	£22
			Earnings	£355
Out-of-home placement	-0.55	0.15	Out-of-home placement	£9,843
<b>Benefits Minus Costs</b>	<b>£7,888</b>			
<b>Cost-benefit Ratio</b>	<b>3.95</b>			

### **ii. Other Family Preservation Services**

<b>Short-term outcome</b>	<b>Effect Size</b>	<b>Standard Error</b>	<b>Long-term outcome</b>	<b>Benefit</b>
Child abuse and neglect	0.09	0.05	Crime	-£30
			Social Services	-£128
			Special Education	-£17
			Health care	-£10
			Earnings	-£170
Out-of-home placement	0.00	0.08	Out-of-home placement	-£47
<b>Benefits Minus Costs</b>	<b>-£2,873</b>			
<b>Cost-benefit Ratio</b>	<b>0.16</b>			

#### iv. Parent Child Interaction Therapy for families in the child welfare system (age 2-12)

Short-term outcome	Effect Size	Standard Error	Long-term outcome	Benefit
Child abuse and neglect	-0.71	0.20	Crime	£161
			Social Services	£1,436
			Special Education	£89
			Health care	£47
			Earnings	£851
<b>Benefits Minus Costs</b>	<b>£1,310</b>			
<b>Cost-benefit Ratio</b>	<b>2.03</b>			

IFPS have also been implemented and evaluated in the UK. For example, Option 2 is a Welsh intensive family preservation service based on the US Homebuilders model. It aims at reducing the need for children to enter care from families experiencing parental substance misuse (Forrester *et al.*, 2008b).<sup>119</sup> The reduction of time spent in care meant that there were considerable cost savings (over £1000 per child in one of the participating local authorities).

These results suggest the way in which improvement in one early outcome can yield future benefits in many different areas in a child's life. Moreover, some outcomes lead to benefits via multiple intermediate steps. For example, a reduction in child abuse and neglect can lead to savings for social services but also to improvements in cognitive functioning, better educational outcomes and reduced depression, and thus to increased earnings. Similarly, multiple early outcomes can contribute in combination to the same benefit, such as reductions in disruptive behaviour and improved educational outcomes leading to children's increased projected earnings as adults.

Axford *et al* (2015, 2016) report a wide variation in the cost-benefit ratios across the range of programmes. This can be due to a mismatch between the intensity (and therefore cost) of a programme and the risk of poor outcomes in the target population, or because the trial of a particular interventions has reported small effect sizes. It may also be because some outcomes are not yet monetisable in this model, so some interventions may be making important changes for children which cannot (yet) be accounted for in terms of monetary benefits. Information about costs and benefits of an intervention must always be considered alongside the wider evidence of impact on the wellbeing of children and families.

The length of time between the early effects of an intervention and the accumulation of monetary benefits varies. In some cases, these benefits are relatively immediate, as in the case of a reduction in the need for special education services or out-of-home placements. In other cases, a long time passes before a particular benefit is realised, such as increased future lifetime earnings due to a reduction in mental health problems in early childhood.

With the exception of these examples, most studies included in Axford *et al.* 2015 and 2016 are predominantly focused at primary and secondary level, with families in demographically high risk groups. However, Ofsted (2011) reviewed of a sample of local approaches to diverting

<sup>119</sup> Forrester, D. and Harwin, J. (2008) 'Parental substance misuse and child welfare: outcomes for children two years after referral.' *British Journal of Social Work* 38, 8, 1518–1535.

young people from care found that all areas reported demonstrable savings.<sup>120</sup> These ranged from £93,000 for one family alone, to £688,000 in total savings for a children's services budget.

#### **iv. Family Drug and Alcohol Courts**

Cost benefit analysis of interventions led by Family Drug and Alcohol Courts (FDAC) involved small samples but also produced encouraging results (Harwin *et al.*, 2011<sup>121</sup> cited in Ward 2014). Data suggest that local authorities saved £682 per FDAC family on court hearings and £1,215 per family on the provision of expert evidence to the court. Financial savings in FDAC cases were made because assessments performed 'in house' by the FDAC team were less expensive than those undertaken by independent experts in ordinary proceedings; children spent less time in out-of-home-placements; and there were fewer contested hearings (Ibid.)

#### **v. Intensive Intervention Projects**

An evaluation of the impact of Intensive Intervention Projects – designed to 'turn around' the lives of the most challenging and troubled young people – found that the IIPs '*generated average savings from prevented expenditure over five years with an average present value of about £280,000 per person ... With a return of £8 of savings per £1 spent, these figures indicate significant quantifiable cost-benefits from the intervention*' (Flint *et al.*, 2011).<sup>122</sup>

#### **vi. Targeted Youth Services**

Despite a thorough search by O'Mara *et al.* (2010) for cost-effectiveness data on Targeted Youth Services (TYS) very little was identified. The authors were not able to conclude whether TYS interventions are offering a good return on investment, in spite of some promising trends. This is one of several areas on which further rigorous research is needed.

### **Summary**

Rigorous cost-benefit analysis is limited especially in the UK context, but existing studies in this and other contexts consistently show the way that improvement in one early outcome can yield future benefits in many different areas in a child's life; and some outcomes lead to benefits via multiple intermediate steps (Axford *et al.* 2015). For example, a reduction in child abuse and neglect can lead to savings for social services but also to improvements in cognitive functioning, better educational outcomes and reduced depression, and thus to increased earnings. Similarly, multiple early outcomes can contribute in combination to the same benefit, such as reductions in disruptive behaviour and improved educational outcomes leading to increased projected earnings in adult life (Ibid.). These pathways are complex but merit further study and analysis.

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<sup>120</sup> Ofsted (2011) *Edging away from care – how services successfully prevent young people entering care*. London: Ofsted. Available online: [http://dera.ioe.ac.uk/12278/2/Edging\\_away\\_from\\_care\\_-\\_how\\_services\\_successfully\\_prevent\\_young\\_people\\_entering\\_care%5B1%5D.pdf](http://dera.ioe.ac.uk/12278/2/Edging_away_from_care_-_how_services_successfully_prevent_young_people_entering_care%5B1%5D.pdf) (Accessed 10/09/16)

<sup>121</sup>

Harwin, J. *et al.* (2016) *After FDAC: outcomes 5 years later: A continuation study of the first Family Drug and Alcohol Court (FDAC) in care proceedings*. University of Lancaster. (See: <http://fdac.org.uk/wp-content/uploads/2016/09/FDAC-Report-final-1.pdf> Accessed 18/01/17).

<sup>122</sup> In Hanson, E. & Holmes, D. (2014) *That Difficult Age: Developing a more effective response to risks in adolescence*. Dartington: Research in Practice.

## 4. Conclusion

This report is the result of a rapid review which presents a broad summary of recommendations from secondary data sources (e.g. systematic reviews) of varying quality. Where key methods of working were not included in reviews we identified relevant primary research. There are, however, significant gaps in the evidence, and in particular regarding recent innovations in practice. This means that information regarding many new initiatives such as MARAC and MASH are limited to local descriptions of their implementation. It is to be hoped that this situation will be remedied by the DfE Innovation Programme.

## 6. CRITICAL APPRAISAL OF INCLUDED STUDIES TABLES

Table 2: Assessment

### *Assessment of child maltreatment*

**Note:** Ward (2014) summarises evidence on a number of different subjects relating to parental capacity to change in families where there are significant child protection concerns. This table reports on findings related to assessment. Other subjects such as client provider relationship, motivation to change and interventions are outlined in separate tables.

#### Critical Appraisal

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Ward <sup>123</sup> (2014)	Yes	Papers based on empirical data. Priority given to systematic reviews and meta analyses over individual papers.	Yes	A wide range of papers were selected including recent research reports. Before publication, were subject to an equivalent rigorous peer review process as academic journal articles."	<b>Papers related to assessment and decision making in relation to children 0 – 18 on the edge of care)</b>  Rigid inclusion/exclusion criteria "were not applied as it was important to gain an overview of the range of literature available."	Narrative	Narrative	Yes	Yes

<sup>123</sup> Includes some cost benefit analyses.

### 1.2 Content

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Ward (2014)	Structured decision making, risk assessment, shared decision making, family group decision making.	To assist social workers, judges and others in accurately evaluating parental capacity to change in order to prevent future harm to children.	Practitioners tasked to make decisions about children in the edge of care.	A dynamic process of varying length of time. Time involved in application of individual tools not specified.	Parents of children on the edge of care.	When children are on the edge of care, and when decisions are made about looked after children returning to family care.

### 1.3 Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Ward (2014)	<p>A range of studies on risk assessment tools and processes.</p> <p>The precise number of included studies in this or other sections is not specified in this narrative report.</p>	Accuracy of assessment processes and predictive value of tools.	<p>“At least 100” comparative studies show that <b>professional observation and clinical judgments are less accurate in predicting future behaviour than the actuarial methods upon which validated risk assessment tools are based.</b> Both are required.</p> <p>No tool will be 100% reliable, and standardised actuarial instruments are only 70%-80% accurate in identifying risks of future harm. Such tools are a valuable aid to structured professional decision-making, but they cannot replace professional observation and judgment.</p> <p>Many of tools require further validation in the UK before they can be relied upon. Only a limited number of standardised tools are routinely used in a small number of local authorities in England.</p> <p>One systematic review identified 16 tools currently available:</p> <ul style="list-style-type: none"> <li>• <b>Risk assessment tools</b> that measure a small number of historical and static risk factors that research has shown to be strongly associated with future harm. The evidence</li> </ul>	<ul style="list-style-type: none"> <li>• Domestic abuse, substance misuse, mental health problems and learning disability undermine parenting capability and increase the likelihood of significant harm, particularly when they occur in combination. Parents are also influenced by stressors within the wider environment and family, such as poor housing, poverty and unemployment. Furthermore, these factors can underpin or exacerbate mental ill-health.</li> <li>• There is an extensive and growing evidence base showing how the experience of abuse and neglect may have a long-term, negative impact on children’s physical, cognitive, social, emotional and behavioural development that can last throughout the life course.</li> <li>• Judgments require <b>structured professional decision-making</b> where experience is supported, but not replaced, by use of evidence-based tools standardised and validated within a UK context.</li> </ul>

		<p>supported the use the <b>California Family Risk Assessment Tool</b> included in the Children’s Research Centre Structured Decision-Making System (CRC-SDM). It needs to be further validated in the UK.</p> <ul style="list-style-type: none"> <li>• <b>Strengths and Needs Assessment tools</b> that typically measure dynamic factors that are often defined as needs and which, if remedied, can reduce the risk of harm posed. The review identified two tools developed in the UK: <b>the Graded Care Profile</b> and the <b>Safeguarding Assessment and Analysis Framework</b> which appeared most effective but need for formal piloting in the UK to test for reliability, validity, impact and acceptability.</li> <li>• <b>Response Priority Decision Trees:</b> tools that are used to ‘improve the consistency across workers and to prioritise decisions about initial reports of abuse and neglect, in order to focus the workload and aid decision-making. <b>The CRC-SDM Response Priority Decision Trees</b> meet this requirement but again the review indicates that they would require testing in a UK setting.</li> <li>• <b>Permanency/Placement and Reunification Checklists</b> have been developed as part of the <b>CRC-SDM structured decision-making system</b> and focus explicitly on the likelihood of recurrence of harm in relation to decisions about permanency/ placement and reunification’ but also need testing in the UK..</li> <li>• <b>Audit Tools</b>, which are similar to the risk assessment tools, but have been used to date as a means of auditing retrospectively whether cases have been classified accurately. <b>Ward, Brown and Westlake’s (2012) risk classification</b> was found to offer the most dynamic methodology for identifying risks and setting goals and timescales in consultation with parents when reunification is being considered. This is currently being piloted and evaluated by the NSPCC.</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment requires consideration of the <b>individual and wider environmental problems; how multiple problems interlock;</b> and potential impact of coercion or pressure on <b>parents to present themselves in a positive light.</b></li> <li>• <b>Assessment should be a dynamic process</b> in which strengths and weaknesses are identified, targets set and agreed, effective interventions identified and implemented and progress monitored over a specific time period.</li> <li>• <b>Conceptual models</b> are necessary to provide a framework to analyse factors that influence parents’ ability to meet their children’s needs and assess the likelihood of change.</li> </ul>
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**Assessment of child maltreatment<sup>124</sup>**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Bartelink (2015)	Yes	Range of study designs: Systematic reviews (4), non-systematic reviews (1), RCTs (6), pre-post, correlation studies, 'vignettes'	Yes	No	Included studies were limited to children and youth (0–18 years) or parents.  The main subject of the article had to be decision-making on child maltreatment.  Studies on medical decision-making, youth delinquency or physical or mental disabilities were excluded	Narrative	Narrative	Yes	Not stated

<sup>124</sup> **These are:**

Barlow, J., Fisher, J. D., & Jones, D. (2012). *Systematic review of models of analysing significant harm*. Oxford: Oxford University.

Léveillé, S., & Chamberland, C. (2010). Toward a general model for child welfare and protection services: A meta-evaluation of international experiences regarding the adoption of the Framework for the Assessment of Children in Need and Their Families (FACNF). *Children and Youth Services Review*, 32, 929–944.

Shlonsky, A., & Saini, M. (2011). *Family Group Decision-Making for Children at Risk of Child Maltreatment*. Paper presentation on the Society for Social Work and Research 15th Annual Conference. Downloaded from <http://sswr.confex.com/sswr/2011/webprogram/Paper15013.htm>

Vis, S. A., Strandbu, A., Holtan, A., & Thomas, N. (2011). Participation and health: A research review of child participation in planning and decision-making. *Child and Family Social Work*, 16, 325–335

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Bartelink (2015)	Structured decision making, risk assessment, shared decision making, family group decision making.	Stop child maltreatment and / or diminish its consequences.	Practitioners tasked to make decisions about response to child maltreatment	When child abuse is suspected or detected	Not specified	Not specified

**Results**

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Bartelink (2015)	17 papers comparing several instruments or measuring impact of one instrument to using no instruments on decision making regarding child maltreatment.	Effectiveness of assessment measures in achieving; protection for parents and children experiencing child maltreatment; cessation of abuse; and/or amelioration of the impact of maltreatment.	<p><b>Structured decision making:</b> Structured decision-making has created a greater child-centred and holistic approach that takes the child’s family and environment into account, which has made practitioners work more systematically and improved the analysis of complex situations. However, this approach has not improved inter-rater agreement on decisions made.</p> <p><b>Risk assessment:</b> actuarial risk assessment instruments perform slightly better than consensus-based risk assessment instruments, although some researchers found that the predictive validity of these instruments did not outperform clinical judgement.</p> <p><b>Shared decision making:</b> studies on shared decision-making are scarce. Nevertheless some promising results were found. Additional studies on motivational interviewing and solution-focused casework showed some positive results on child safety and parenting skills.</p> <p><b>Family group decision making/family group conferencing:</b> Effects on child maltreatment outcomes are addressed in only a few studies. Some of these showed no effects or negative effects of family group decision-making.</p>	<p>Research on decision-making processes in child welfare and child protection is still rare.</p> <p>Shared decision-making may improve the participation of parents and children and the quality of decisions by taking client treatment preferences into account in addition to scientific evidence and clinical experience.</p>

**Family Group Conferences**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Frost (2014b)	Yes	Reviewers did not otherwise apply rigid inclusion/exclusion criteria.	Not a systematic review	No	Any study design included	Narrative	Narrative	Yes	Not discussed in the paper.

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Frost (2014b)	Family Group Conferences	To 'empower' families to make better decisions for their lives in order to improved family functioning.  Reduced child maltreatment, improved parenting,	Trained professionals.	Each FGC is a single event (which may be repeated). It has four stages:  1 - Preparation stage – Coordinator spends time with family members, mediating and preparing them for the conference. 2 - information-giving stage at the beginning of the actual conference. Professionals share concerns with the family and the family ask professionals any questions that they may have. 3 - Private family time where the professionals leave the family alone to produce a plan 4- Family sharing their plan with professionals. If the plan does not leave the concerned child 'at risk', then the professionals are asked to agree to the plan.	Families with child protection concerns. Setting varies but is agreed with the family.	When there are child protection concerns that do not merit the immediate removal of the child.

**Results**

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Frost (2014b)	Quantitative and qualitative studies evaluating the impact of FGCs.	<p>Child abuse and neglect</p> <p>Out of home placements for children</p>	<p>The process evidence is overwhelmingly positive showing that FGCs are valued by families and professionals.</p> <p>The relatively small number of studies on outcomes finds mixed results for FGC; some studies have reported positive outcomes whilst others have reported no impact on conditions of the child.</p> <p>There is wide variation in the application of the model in different contexts. This can include many aspects including referral pathways, location, adherence to protocols and forms of delivery, the attitude of the professionals and family members, their relationship, and the skill of the coordinator. One study (Berzin <i>et al.</i> xx)<sup>125</sup> on FGDM suggests that projects may focus too heavily on the preparation stage and conference itself and neglect the important post-conference stage. This would suggest that families need more support following the FGC in carrying out the plan.</p> <p>Increased scrutiny of the family may also lead to higher levels of detection of child abuse and neglect and therefore to out of home placements.</p>	<p>There is a need for more longitudinal studies to examine if, as theory suggests, FGCs can affect change and subsequently produce positive outcomes for children. Whatever these results, however, it is important to note that FGCs can provide an environment in which empowerment can occur. Even the most rigorous study which found no evidence that that FGCs are effective in terms of outcomes for children, did do not disqualify the use of FGCs.<sup>126</sup></p>

<sup>125</sup> Berzin, S.C *et al.* (2008) Does *family group decision making* affect child welfare outcomes? Findings from a randomized control study. *Child Welfare*, **87** (4), 35–54.

<sup>126</sup> Sundell, K. & Vinnerljung, B. (2004) Outcomes of family group conferencing in Sweden: a 3-year follow-up. *Child Abuse & Neglect*, **28**, 267–287.

**Instruments used in Assessment**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Bailhache (2013)	Yes	Comparative studies of any design.  Descriptive studies with only one group of abused or non-abused children, if the aim was to estimate one accuracy parameter.	Yes	Yes	Included articles including original data that 1) estimated at least one accuracy parameter (sensitivity, specificity, predictive value or likelihood ratio) of a test identifying abused children 2) included a reference standard to determine whether a child had actually been abused; 3) described the assessed test and not just the result of this assessment.  The review excluded tests to identify abusive caregivers, abused children after their death or children victims of intimate partner violence. Studies were excluded that involved only the opinion of caregivers who had been asked whether their children were abused or not.	Individual test results.	Cis	Yes	Not discussed in detail. Inaccuracy of instruments can result in false positives and false negatives which increases cost as well as having profound ethical and practical implications.

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Bailhache (2013)	Evaluation of predictive value of instruments designed to identify abused children before their death and assess if any were adapted to screening.	Early identification of risk of child abuse.	Medical, social or judicial workers.	Application of one or more tools/measures at least two points. Gap between tests was inconsistently reported.	Parents and children in cases of suspected child abuse. No setting was excluded.	Abuse is suspected

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Bailhache (2013)	<p>Prospective (8) and retrospective (5) studies to assess diagnostic accuracy of assessment tools.</p> <p>Thirteen studies were selected, of which seven dealt with physical abuse, four with sexual abuse, one with emotional abuse, and one with any abuse and physical neglect. Study quality was low, even when not considering the lack of gold standard for detection of abused children.</p>	Accuracy of tools in early identification of abuse.	<p>Study quality was reported to be low.</p> <p>In 11 of 13 studies, instruments identified abused children only when they had clinical symptoms. Sensitivity of tests varied between 0.26 (95% confidence interval [0.17-0.36]) and 0.97 [0.84-1], and specificity between 0.51 [0.39-0.63] and 1 [0.95-1].</p> <p>The sensitivity was greater than 90% only for three tests:</p> <p><b>Physical abuse:</b> the absence of scalp swelling to identify children victims of inflicted head injury<sup>127</sup>; a decision tool to identify physically-abused children among those hospitalized in a Paediatric Intensive Care Unit.<sup>128</sup></p> <p><b>Sexual abuse:</b> a parental interview integrating twelve child symptoms to identify sexually-abused children.<sup>129</sup></p> <p>When the sensitivity was high, the specificity was always smaller than 90</p>	<p>There is very scarce and low-quality evidence on the accuracy of instruments for identifying abused children.</p> <p>Child maltreatment is mostly identified when children have already serious consequences and the sensitivities and specificities of tools are inadequate. Before considering a screening program of child maltreatment, better knowledge on the beginning of child maltreatment and development of valid screening instruments at subclinical stages remain necessary.</p> <p>A screening program should also be acceptable to families and professionals.</p> <p>Unreliable assessment tools carry the risk both of false negatives (children identified wrongly as not abused) and of false positives (children identified wrongly as abused and parents identified wrongly as abusers). The stigmatization of families is an important ethical issue.</p>

<sup>127</sup> Vinchon M, De Foort-Dhellemmes S, Desurmont M, Delestret I (2010) Confessed abuse versus witnessed accidents in infants: comparison of clinical, radiological, and ophthalmological data in corroborated cases. *Childs Nerv Syst* 26(5):637–645.

<sup>128</sup> Pierce MC, Kaczor K, Aldridge S, O'Flynn J, Lorenz DJ (2010), Bruising characteristics discriminating physical child abuse from accidental trauma. *Pediatrics*, 125(1):67–74.

<sup>129</sup> Wells R, McCann J, Adams J, Voris J, Dahl B (1997) A validation study of the structured interview of symptoms associated with sexual abuse (SASA) using three samples of sexually abused, allegedly abused, and nonabused boys. *Child Abuse Negl*, 21(12):1159–1167.

*Relationship between assessment and outcomes*

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Turney (2011)	Yes	A wide range of studies. One of the aims of the study was to draw out 'hidden' findings on assessment from a wide range of different reports and documents.	Yes	No.	<p>Tools and strategies to assess children in need (0-18) is included, e.g.</p> <ul style="list-style-type: none"> <li>• Initial and core assessments using the <i>Framework for the Assessment of Children in Need and their Families</i> (DH et al., 2000)</li> <li>• Assessments carried out using the Common Assessment Framework</li> <li>• Other aspects of the Integrated Children's System, including arrangements for reviewing Looked After Children</li> <li>• Assessments under Regulations 28 and 39 of the Fostering Services Regulations</li> <li>• Child Permanence Reports or Form E assessments of children to be placed for adoption</li> <li>• Health, education and other 'specialist' assessments</li> </ul> <p>Papers were excluded if the focus was on:</p> <ul style="list-style-type: none"> <li>• Evaluations of intervention/treatment;</li> </ul>	Narrative	Narrative	Yes	Not stated

				<ul style="list-style-type: none"> <li>• Adults (for example foster carer or adopter assessments);</li> <li>• Parental need or specific parenting difficulties (e.g. post-natal depression or parenting where alcohol abuse is a factor). However, studies addressing parenting <i>capacity</i> have been included;</li> <li>• The use/usefulness of different assessment tools and questionnaires/scales;</li> <li>• Addressing factors that promote/inhibit access to services;</li> <li>• Individual case studies.</li> </ul>				
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## Content

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Turney (2011)	<p>Studies on assessment that identified:</p> <ul style="list-style-type: none"> <li>• quality of the data populating initial, core and other types of assessments</li> <li>• variation in the quality of assessments by local authority and by different groups of children;</li> <li>• factors that assisted or acted as barriers to good quality assessments of children in need;</li> <li>• thresholds operated by local authorities for responding to referrals, and implications for outcomes for children in need and their families;</li> <li>• extent to which professionals engaged with children, young people and their families to produce effective assessments;</li> <li>• impact of the quality of assessments on decision-making, planning, interventions and ultimately on children's and young people short and longer term outcomes.</li> </ul>	Accurate assessment of actual or potential harm.	Assessment is undertaken by social, medical and police/judicial professionals.	Not specified	Not specified	Not specified

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Turney (2011)	135 papers that ranged from peer reviewed empirical research, government reports, and 'grey' literature.	<ul style="list-style-type: none"> <li>• Thresholds operated by LAs for responding to referrals.</li> <li>• Quality of data populating assessments for children in need, including looked after children and children placed for adoption</li> <li>• Variation in quality of assessments by LAs and for different groups of children</li> <li>• Extent of engagement of children, young people and families by professionals in making assessments</li> <li>• Barriers and facilitators</li> <li>• Impact of assessments on decision making, planning, interventions and outcomes for children/young people</li> </ul>	<p><b>The following is a brief summary of key findings.</b></p> <p><b>Thresholds:</b> Thresholds vary among LAs, are affected by funding considerations, and are particularly difficult to assess in the case of emotional abuse and neglect.</p> <p><b>Quality and content:</b> Varied among LAs. Research highlighted a need for further professional education in relation to identity, resilience, self-esteem, attachment, and the identification of the specific behavioural problems which contribute to poor placement outcomes for looked after children.</p> <p>Good quality assessments:            (i) Ensure that the child remains central (ii) Contain full, concise, relevant and accurate information (iii) Include a chronology and/or family and social history (iii) Make good use of information from a range of sources (iv) Include analysis that makes clear links between the recorded information and plans for intervention (or decisions not to take any further action).</p> <p><b>Extent of engagement by children and families</b>            Engagement of children and quality also vary across authorities. Barriers to involving children include: time constraints; insufficient skills; lack of confidence in conducting direct work or undertaking child observations; and insufficient support. In addition, some parents make it difficult for workers to see the child and/or overwhelm workers with their own difficulties.</p> <p><b>Barriers to quality assessment operate at several levels:</b></p>	<p>Good assessment matters and should be underpinned by a clear focus on the child and careful attention to analysis. Without the solid foundation of a holistic and ecologically informed assessment, the edifice of professional interventions is unsafe.</p> <p>However, it takes time, resources and appropriate supporting tools and materials to do well. In addition, since assessment makes a range of practical and emotional demands on practitioners, good access to reflective supervision is essential.</p> <p>Overall, the review suggests the need to put assessment knowledge and skills centre stage in practice, in management, and in training. This requires a more clinically focused approach and opportunities at different levels to learn and develop assessment knowledge and skills.</p> <p>There are clear messages from research about the factors that help to promote effective practice and improve the quality of assessments. These can be used to create a climate in which practitioners are supported to make the best assessments they can in order to provide interventions that improve the lives of children and their families.</p> <p>Nevertheless, it should be noted that assessment is not a panacea. A number</p>

			<ul style="list-style-type: none"> <li>• Personal - including whether or not the practitioner feels competent and confident to carry out the required tasks, and has the scope to do so within their individual case load;</li> <li>• Inter-personal/ relational - including the range of activities involved in communicating with children and young people, parents, and other professionals;</li> <li>• Systems issues - including increasing dependence on complex and sometimes unreliable or unwieldy procedures or IT systems; and the sense of lack of time for face-to-face work as a result of time spent inputting data; and</li> <li>• Organisational constraints - including the organisational culture, for example whether or not there is a commitment to reflection and learning, management of workloads and so on - and level of resource. The outcomes of assessments often depend on there being adequate resources to implement plans.</li> </ul> <p><b>Factors that enable quality in assessment:</b></p> <ul style="list-style-type: none"> <li>• A knowledgeable, highly skilled and confident workforce, supported by appropriate education, training and continuing professional development;</li> <li>• A clear framework for reflective 'clinical' supervision (individual and/or group) and other forms of case-based consultation, including support for practitioners working directly with children;</li> <li>• An adequate level of resource – in terms of time and staffing, as well as services – to allow practitioners to complete assessments and plan appropriate interventions in a thorough but timely manner;</li> </ul>	<p>of other variables can affect outcomes, including the degree of difficulty experienced by the child in question and the availability of resources.</p>
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			<ul style="list-style-type: none"> <li>• Good intra-organisational and inter-professional working relationships;</li> <li>• An organisational culture that supports reflection and learning (not a 'blame culture');</li> <li>• Electronic information management and recording systems that 'work with' practice, are reliable and not unnecessarily time-consuming; and</li> <li>• 'Organisational health checks' or audits of the quality of assessments undertaken.</li> </ul> <p><b>Impact of assessment:</b></p> <p>Parents' and children's reactions to the experience of assessment and related interventions were, on balance, positive and findings suggested improvements in relationships between social workers and parents in the UK between the 1990s and the 2000s.</p> <p>In relation to safeguarding, good assessment appeared likely to lead to better outcomes for children.</p> <p>Early intervention is -emphasised, and assessment can assist in the effective targeting of interventions.</p>	
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**Identification and assessment of families in complex child protection cases.**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Thorburn (2009)	Yes	Range of study designs and other narrative reports	Not stated	No	Not specified	Narrative	Narrative	Yes	Not assessed

**Content**

Author (Year)	Intervention(s) reviewed <sup>130</sup>	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Thorburn (2009)	Strategies for identification and assessment of families in complex child protection cases.  Interventions designed to ensure child protection and improve child wellbeing.	Prevention of further maltreatment or significant impairment to the child's development.	Varies	Varies	Varies	Not specified.

**Results**

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Author (Year)	Included studies	Relevant Outcomes measured	Results	Author's conclusions
Thornton (2006)	Non-systematic review of the literature on a identification, assessment, engagement and interventions. Broad range of studies.	<p>Identifying complex child protection cases</p> <p>Effective assessment and decision-making</p>	<p>Front-line staff in agencies providing universal services are central to the early identification and provision of effective services to complex families who are characterised as <i>hard to reach</i> and <i>hard to change</i>. It is therefore essential that front-line staff receive appropriate training in assessment skills.</p> <p>Multi-disciplinary assessment of <i>the overall profile of the family's past and present functioning</i> as well as the <i>type of maltreatment</i> is essential to the achievement of sound and cost-effective decisions about duration and intensity of the service needed to prevent re-abuse.</p> <p>With complex cases solution-focused approaches must be preceded by a full psycho-social history.</p>	<p>Whilst there is a growing knowledge base about promising approaches to supporting families and changing harmful parenting practices in complex child protection cases, there is no clear message from research that any specific service approaches or methods will be effective with abusing families.</p> <p>Policy-makers should identify broadly how many of what sorts of potentially maltreating families exist in their area. The knowledge is there to help them to do this, in that much is now known about the impact of a range of parenting behaviours, histories, contexts and relationships on children's lives. This involves attention at a community as well as an individual case level.</p> <p>This should bring together individual risk assessment, analysis of needs and risk of maltreatment, which can then be matched with an audit of how the approaches and services currently available fit with what is known about best professional practice across the disciplines. We are still some way away from having a 'menu' of methods known to be effective, particularly with complex families who are hard to reach and hard to change. It is therefore essential that practice developments are reported and shared in order to promote the development of knowledgeable and creative options.</p>

Table 3: Motivation and retention of parents in treatment

**Note:** Ward (2014) summarises evidence on a number of different subjects relating to parental capacity to change in families where there are significant child protection concerns. This table reports on findings related to parental motivation to change. Other subjects such as assessment, interventions and social work are outlined in separate tables.

**Motivation to change**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Ward (2014)	Yes	Papers based on empirical data. Priority given to systematic reviews and meta analyses over individual papers.  Reviewers did not otherwise apply rigid inclusion/exclusion criteria.	Yes	A wide range of papers were selected including recent research reports. Before publication, those “were subject to an equivalent rigorous peer review process as academic journal articles.”	<b>Papers related to assessment and decision making in relation to children 0 – 18 on the edge of care)</b>  Rigid inclusion/ exclusion criteria “were not applied as it was important to gain an overview of the range of literature available.”	Narrative	Narrative	Yes	Yes. The review makes reference to some economic data and cost benefit analysis.

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Ward (2014)	The review as a whole includes 343 papers focusing on: assessment; interventions; social work practice in relation to families with a child or children on the ‘edge of care.’  This section focuses on motivation to change.	To assist practitioners in enhancing parental motivation to change.	Practitioners working with parents of children in the edge of care.	A dynamic process of varying length of time.	Parents of children on the edge of care.	When children are on the edge of care.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Ward (2014)	<p>Experimental studies on impact of different approaches to motivating change.</p> <p>The precise number of included studies in this or other sections is not specified in this narrative report</p>	Behavioural change of parents in drug and/or alcohol treatment.	<ul style="list-style-type: none"> <li>• <b>The Family Partnership Model (FP), Motivational Interviewing (MI) and Family Group Decision-Making (FGDM) offer potential methods of engaging parents</b> who are ambivalent about change, mistrustful of social workers, or not fully ready for change. Such methods can empower parents by giving them an element of control. FGDM also enables families to participate in the decision-making process.</li> <li>• <b>Social Behaviour and Network Therapy (SBNT)</b> A large UK RCT compared SBNT in treating alcohol addiction with that of Motivational Enhancement Therapy (an approach based on MI). It found that both groups reported substantial reductions in alcohol dependence and problems, and better mental health-related quality of life over the subsequent twelve months. However, SBNT did not differ significantly in effectiveness and cost effectiveness from Motivational Enhancement Therapy (a form of MI).</li> <li>• <b>Family Drug and Alcohol Courts (FDAC)</b> Evaluation of family drug treatment courts in the USA and UK FDAC pilot found intervention effects favouring the intervention on decreased substance misuse. Data from the second UK study also indicate that FDAC may be more successful in engaging and supporting fathers than ordinary proceedings. Emerging UK evidence, based on a small sample of fewer further episodes of abuse or neglect in FDAC than in comparison families at one year follow up.</li> </ul>	<ul style="list-style-type: none"> <li>• Motivation to change cannot be easily predicted. However, a theoretical model of the different factors that promote or inhibit parental engagement with child welfare services can facilitate a greater understanding of issues that need to be addressed and serve as a framework for assessing how far parents are ready and willing to change.</li> <li>• Platt's (2012) integrated theoretical model, designed for use in child safeguarding/ welfare in the UK, is recommended. It can facilitate a greater understanding of issues that need to be addressed and serve as a framework for assessing how far parents are ready and willing to change.</li> <li>• <b>Behaviour change incorporates common elements</b> including resistance, ambivalence, motivation, engagement and action. Lapse or relapse is also viewed as an integral part of the change process.</li> <li>• False compliance, failure to cooperate and denial are common. <b>Parents may be resistant to the involvement of social workers rather than resistant to change in itself</b>, particularly where they feel social workers are exercising power <i>over them</i> instead of <i>with them</i> in a supportive manner.  Parents may turn to other professionals, seen as less threatening, or whose involvement attracts less stigma. <b>Social workers must develop good inter-agency links with other professionals</b> such</li> </ul>

				<p>as health visitors and practitioners in adult services to maximise engagement with parents.</p> <ul style="list-style-type: none"><li>• <b>Relationships are critical to achieving change.</b></li><li>• <b>The Family Partnership Model (FP), Motivational Interviewing (MI) and Family Group Decision-Making (FGDM) offer potential methods of engaging parents</b> who are ambivalent about change, mistrustful of social workers, or not fully ready for change. Such methods can empower parents by giving them an element of control. FGDM also enables families to participate in the decision-making process.</li></ul>
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**Motivation and engagement of families in complex child protection cases.**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Thorburn (2009)	Yes	Range of study designs and other narrative reports	Not stated	No	Not specified	Narrative	Narrative	Yes	Not assessed

**Content**

Author (Year)	Intervention(s) reviewed <sup>131</sup>	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Thorburn (2009)	Strategies for identification and assessment of families in complex child protection cases.  Interventions designed to ensure child protection and improve child wellbeing.	Prevention of further maltreatment or significant impairment to the child's development.	Varies	Varies	Varies	Not specified.

**Results**

Author (Year)	Included studies	Relevant Outcomes measured	Results	Author's conclusions
Thornton (2006)	Non-systematic review of the literature on a identification, assessment, engagement and interventions. Broad range of studies.	professional relationship between services, children and families	<p>Many parents, as well as children and young people who suffer from neglect and maltreatment, mistrust formal services. It is therefore necessary that parents and children feel that they are not stigmatised when seeking help and that they retain an appropriate degree of control over subsequent stages of the support and protection process.</p> <p>Gaining the cooperation of complex families requires services to be dependable and professional. This includes providing assistance that from the outset is educative, supportive and timely.</p> <p>Complex cases are likely to require a long-term relationship with the children's social services. Open discussion about the nature of this relationship over time and about short-term and long-term types of support can promote this engagement.</p>	<p>Whilst there is a growing knowledge base about promising approaches to supporting families and changing harmful parenting practices in complex child protection cases, there is no clear message from research that any specific service approaches or methods will be effective with abusing families.</p> <p>Policy-makers should identify broadly how many of what sorts of potentially maltreating families exist in their area. The knowledge is there to help them to do this, in that much is now known about the impact of a range of parenting behaviours, histories, contexts and relationships on children's lives. This involves attention at a community as well as an individual case level.</p> <p>This should bring together individual risk assessment, analysis of needs and risk of maltreatment, which can then be matched with an audit of how the approaches and services currently available fit with what is known about best professional practice across the disciplines. We are still some way away from having a 'menu' of methods known to be effective, particularly with complex families who are hard to reach and hard to change. It is therefore essential that practice developments are reported and shared in order to promote the development of knowledgeable and creative options.</p>

Table 4: Practitioner role, management and training

**Client-provider relationship and treatment outcomes**

**Critical appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Marsh (2012)	Yes	Experimental and quasi experimental designs.	Yes	Not clear	<p>Studies that that use quantitative measures to assess the relationship of client-provider relationship and service outcomes across 3 service sectors: substance abuse, child welfare, and mental health.</p> <p>Paper excluded: descriptive cases studies; studies investigating the client-provider relationship in group treatment.</p> <p>Also excluded studies that involved only medical professionals (nurses, primary care physicians), studies that involved patients with a primary medical condition, and studies that sampled only children or adolescents.</p>	Individual study results; narrative.	Significant or non-significant effects but no details on effect sizes.	Yes	Not assessed

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Marsh (2012)	<p>The review as a whole includes 60 research reports meeting inclusion criteria: 25 in substance abuse, 7 in child welfare, and 28 in mental health. This table reports only on studies relating to child welfare, of which three were forms of primary prevention.</p> <p>Four pre-post studies involving children at risk of removal from family. The review as a whole included 60 studies that measured the impact of client provider relationship on outcome relating to substance abuse, mental health, and child protection.</p>	Improve client motivation, engagement, retention, and ultimate outcomes of treatment.	Not specified in the study	Not specified in the study	Two studies involved intervention delivered in community settings, two in the home.	Not specified in the study

**Results**

Author (Year)	Included studies	Relevant Outcomes measured	Results	Author's conclusions
Marsh (2012)	<p>Studies of child welfare interventions that measured impact of client-provider relationship.</p> <p>Of these, four pre-post studies had a focus on family preservation / children with reported abuse<sup>132</sup>.</p>	<p><b>Intermediate outcomes:</b> Participation</p> <p><b>Ultimate outcomes:</b> Child safety Permanency Parent and family wellbeing</p> <p>Impact of intervention setting on outcomes</p>	<p><b>Intermediate outcomes:</b></p> <p><b>Participation:</b> Not measured in studies for families with reported abuse or children on the edge of care. However, it was measured in two preventive targeted programmes for child welfare was found to have a positive association. A good client-practitioner relationship was central to engagement, retention and completion.</p> <p><b>Ultimate outcomes:</b></p>	<p>The quality of client- provider relationship is a consistent predictor of process (participation and retention) and a somewhat less consistent predictor of outcomes in all three types of services included in this paper (substance abuse, mental health as well as child welfare).</p> <p>Voluntary, in-home, family therapy services tailored and structured to fit the family's needs found a connection between client-provider relationship and outcome. These service setting factors, coupled with the family's risk of having a child removed from the</p>

<sup>132</sup> Altman, J. C. (2008). A study of engagement in neighborhood-based child welfare services. *Research on Social Work Practice, 18*(6), 555- 564. Johnson, L. N., & Ketring, S. A. (2006). The therapy alliance: A moderator in therapy outcome for families dealing with child abuse and neglect. *Journal of Marital and Family Therapy, 32*, 345-354.; Johnson, L. N., Wright, D. W., & Ketring, S. A. (2002). The therapeutic alliance in home-based family therapy: Is it predictive of outcome? *Journal of Marital and Family Therapy, 28*, 93- 102. Lee, C. D., & Ayón, C. (2004). Is the client-worker relationship associated with better outcomes in mandated child abuse cases? *Research on Social Work Practice, 14*, 351-357.

		Impact on overall outcomes	<p><b>Child safety:</b> Measured in 2 studies; positive association between quality of client-provider relationship and safety, particularly in disciplinary practices, emotional care, and reduction in violence.</p> <p><b>Permanency/reunification:</b> Measured in 1 study. No association found.</p> <p><b>Wellbeing:</b> 3 relevant studies that measured safety, permanency and wellbeing found at least a partial association between client provider relationship and measured outcomes.</p> <p>2 relevant studies measures anxious/ depressed symptoms within the family as a whole and for individual members. Although it has content validity, the measure used (Family therapy alliance scale, FTAS) does not have confirmed predictive validity so findings are inconclusive.</p> <p><b>Treatment setting.</b> 2 studies that explored effect on wellbeing of interventions delivered in ‘traditional social welfare settings’ reported mixed findings, with greater safety but not permanency or wellbeing.</p> <p>Two studies that involved interventions in the home or family therapy found a consistent association between the client provider relationship and child/family wellbeing.</p>	home, might create the conditions in which the family and provider are motivated to build a meaningful relationship, and the resulting alliance might improve outcomes.
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### ***Client-provider relationship and treatment outcomes***

**Note:** Ward (2014) summarises evidence on a number of different subjects relating to parental capacity to change in families where there are significant child protection concerns. This table reports on findings related to Client-provider relationship and treatment outcomes. Other subjects such as assessment, motivation to change and interventions are outlined in separate tables.

#### **Critical appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/ exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Ward <sup>133</sup> (2014)	Yes	Papers based on empirical data. Priority given to systematic reviews and meta analyses over individual papers.  Reviewers did not otherwise apply rigid inclusion/ exclusion criteria.	Yes	Yes.	Rigid inclusion/ exclusion criteria “were not applied as it was important to gain an overview of the range of literature available.”	Narrative	Narrative	Yes	Not discussed in this section.

#### **Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Ward (2014)	The review as a whole includes 343 papers focusing on: assessment; interventions; social work practice in relation to families with a child or children on the ‘edge of care’  <b>This section reports findings on client provider relationship.</b>	Increasing parents motivation to change; achieving change;	This section focuses on processes rather than discrete interventions.	A dynamic process of varying length of time.	Families where one or more children are on the “edge of care.”	When children are on the edge of care, and when decisions are made about looked after children returning to family care.

<sup>133</sup> Includes some cost benefit analyses.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Ward (2014)	<p>Survey and case file data, qualitative studies.</p> <p>Precise number of included studies in this or other sections is not specified in this narrative report.</p>	<p>Common features of successful social work practice relating to maltreated children; what parents value in child and family social workers.</p>	<p>Very little systematic evidence based on experimental studies, about social work practice in the UK.</p> <p>Survey and case file data identify the following elements of success in work with maltreated children:</p> <ul style="list-style-type: none"> <li>• assessments leading to the identification of clearly specified goals and targets concerning what needs to be changed; provision of social work and specialist services to support such changes;</li> <li>• careful planning that includes children and families;</li> <li>• and strong proactive case management.</li> </ul> <p>Qualitative data from interviews with parents consistently indicate that they value child and family social workers who are 'not afraid to break bad news' and are straightforward and honest about what needs to change and the likely consequences of failure to do so;</p> <p>Who show sensitivity and are prepared to listen to their point of view and understand their circumstances that use their power to support rather than to penalise them (e.g. helping solve practical problems relating to housing etc.) and who offer practical support and advocacy.</p>	<p>"Social workers who are open, straightforward and clear-sighted, and who adopt a position of respectful uncertainty appear to be most effective in supporting parents through the process of change."</p>

**Improving response of professionals to children exposed to domestic violence**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Turner (2015)	Yes	RCTs and pre-post intervention surveys	Yes	Yes	Any type of intervention or significant change in the national or local policy/ practice intended to facilitate and improve professionals' response to disclosure of DVA with child involvement and improve professionals' response to child maltreatment in the context of DV.	Individual study results	Varied according to the study, from CIs, p values to narrative report	Majority of studies from the US.	Not specified

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Turner (2015)	Educational and structural or whole-system interventions that aim to improve professionals' understanding of, and response to, DVA survivors and their children.	Improve individual or organisational response to children exposed to DV.	Not specified in all cases. Appear to be experienced practitioners from DV services.	From very brief (20 mins) training to 2 hour weekly sessions over 10 weeks.	Individual level studies – primarily students, nurses, paediatric staff and other clinicians; system level interventions: child welfare and DV service providers.	Not specified.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Turner (2015)	21 papers, three randomised controlled trials (RCTs), 18 pre-post intervention surveys. These included 18 training and three system-level interventions	Participants' knowledge, attitudes and clinical competence (e.g. screening practices); impact on stakeholders (medical records, psychosocial wellbeing, satisfaction.)  Institutional: Collaborative practice, knowledge,	Not clear whether any interventions also included focus on children of male victims of DV.	Overall interpretation that training programmes aiming to improve the response of professionals to the exposure of children to DVA can improve participants' knowledge, attitudes and clinical competence up to a year after the intervention.  Some evidence that improvements in perceived competence can be translated into changes in clinical practice, as documented by clinical record audits. However, perceived competence gains were not sustained consistently over time, indicating the need for reinforcement (e.g. booster sessions).  Elements of effective interventions include an added experiential or post-training discussion component (alongside the didactic component), incorporating 'booster' sessions at regular intervals after the end of training, advocating and promoting access to local DVA agencies or other professionals with specific DVA expertise, and finally, drawing from a clear and well-articulated protocol for intervention.

**Increasing staff retention/preventing burnout**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
McFadden (2015)	Yes	Empirical research or reviews of studies. Unpublished student dissertations reporting on empirical data were included.	Yes	No	Studies that focused only on social workers in child protection or child welfare work. Studies related to other professions and areas of social work practice were excluded.  Government papers, policy documents, theoretical material and descriptive case study articles were excluded.	Narrative	Narrative	Yes	Not applicable

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
McFadden (2015)	Studies reporting on the causes of burnout in child protection work.	n/a	n/a	n/a	n/a	n/a

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
McFadden (2015)	65 studies including systematic reviews, surveys, and qualitative studies, and 'grey' literature'.	Factors that contribute to burnout in child protection social workers.	<p>Nine themes were identified in total. These are categorised under 'Individual' and 'Organisational' themes. 'Individual' level themes included personal history of maltreatment, training and preparation for child welfare, coping, secondary traumatic stress, compassion fatigue and compassion satisfaction.</p> <p>Those classified as organisational included workload, social support and supervision, organisational culture and climate, organisational and professional commitment, and job satisfaction or dissatisfaction.</p> <p><b>Individual level themes:</b> A 'personal history of maltreatment' can impact on workers who are dealing with vicarious trauma of others on a daily basis. Personal awareness and personal development are important at the point of entry onto this career, for individuals and educators as well as employers, and this commitment should be a career-long activity.</p> <p>Coping styles are also important in retention. Use of active and engaged coping methods such as cognitive restructuring and problem solving is more effective than avoidant or disengaged methods such as withdrawal and absenteeism.</p> <p><b>Organisational level themes:</b> The major predictors of turnover are not individual, but are work-and organisational-based; therefore there is more that could be done to increase job satisfaction and reduce attrition in this sector. Defensive organisational culture with poor social supports and unmanageable caseloads are related to intention to leave and job exit.</p> <p>Supervisory and peer supports are significant factors which influence commitment, organisational culture and intention to stay or leave.</p> <p>A major contributor to burnout is workload and staff being stretched beyond capacity.</p> <p>Commitment is closely related to turnover or retention of staff. Several studies show that factors that create commitment is within the grasp of managers and policy makers to manipulate.</p>	<p>Staff retention is associated positive coping styles and personal development, good-quality primary and ongoing training, constructive organisational cultures, supportive social and supervisory support, together with manageable workloads.</p> <p>Although it cannot be assumed that all motivation to a social work career has an origin in a personal history of trauma, consideration could be universally applied to anticipate the needs of workers who have experienced trauma.</p> <ul style="list-style-type: none"> <li>• Training at undergraduate and postgraduate levels should include practice placements and preparation for practice should reflect the demands, challenges and realities of the job.</li> <li>• Therefore, coping methods and professional development strategies could become integrated into undergraduate and post-qualifying training to enhance worker resilience.</li> <li>• Individuals need to develop internal resilience by engaging in personal and professional development strategies from the outset of their career so that they can build on these to develop active coping methods and practices.</li> </ul> <p>Examination of culture and climate contributors are recommended to employers, with a specific focus on management and peer support and supervision.</p> <ul style="list-style-type: none"> <li>• It is recommended that employers and policy makers develop a strategic approach to build resilience into the workforce</li> </ul> <p>Authors make a final caution that low turnover is not <i>always</i> indicative of a healthy organisation; a lack of job alternatives could be a more realistic reason why workers remain.</p>

**Table 5: Innovative models of practice**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/ exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Luckock (2015)	Yes	Any study type, including descriptive papers.	Yes	No	<p>Studies that described and/or evaluated specific service developments in the English context in the decade prior to publication.</p> <p>Studies were excluded at this stage if they did not directly address the intended contribution of the innovation to joint working between health-care practitioners and social workers at points of service interface where safeguarding concerns had been raised, and need for statutory social work assessment was indicated or had been undertaken.</p>	Narrative	Narrative	Yes	Not discussed

## Content

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Luckock (2015)	Innovative models of working with children and families developed in England over the previous 10 years.	To develop a safeguarding response proportionate to the nature and level of concerns identified, that is effective in achieving good outcomes for children and parents alike.	Social care professionals and health professionals	Not specified.	Children and parents in situations where child protection concerns have been raised and require assessment followed by a proportionate response.	Not specified.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Luckock (2015)	21 papers that described and/or evaluated specific service developments in the English context 2000 – 2013.	Existence of innovative models of working across health and children's social care services developed in England  Nature and extent of the evidence of their positive impact on multi-agency safeguarding practice	The following types of innovation and response were identified:  - <b>'Screening'</b> : in this case where routine/universal health screening is enhanced by screening for maltreatment specifically. <i>Survey data</i> shows use of social work expertise and/or formal liaison arrangements with community-based health and social work services are preferred where the child is presented in the hospital setting.  <b>'Common assessment'</b> (by now well established) consistent with the idea of a 'whole system' approach introduced in England by the <i>'Every Child Matters, Change for Children'</i> policy (DfES 2004).  <i>Surveys</i> confirm that a <i>standardized model of 'common assessment' (CAF)</i> had become the prevalent methodology within a 'whole systems' service integration. Different findings about common assessment: (i) it has potential to enable <i>parental</i> engagement and risk de-escalation in some cases or (ii) it can lead to reduction relationship quality with families due to dominance in day-to-day practice of adherence to the demands of the procedure.	The very limited number of evaluative studies identified does not allow firm conclusions about the efficacy of any particular logic of innovative service design. There is as yet very limited evaluation of child and family outcomes.  Almost no examples were found of innovation in which participant feedback on the reliability and legitimacy of safeguarding practice is placed centre-stage in service improvement and re-design (for an exception see White et al. 2011/2015)  Nonetheless, review findings to date strongly suggest that the key practice mechanism across all promising innovations <b>is the quality and integrity of the dialogue among all stakeholders</b> , but particularly between the lead practitioner, parents and child (ren). The quality of this dialogue can be facilitated not only by the skills of lead practitioner but also by the service design.

			<p>–<b>‘Multi-agency team working’</b>: includes ‘virtual’ and ‘co-located’ teams, in some cases led from within ‘adult social care’ services.</p> <ul style="list-style-type: none"> <li>• Evidence emerging that <i>traditional modes and tools of risk assessment</i> at the service interface are being re-introduced in the new policy context</li> <li>• The <i>dialogic and diagnostic functions of standardized tools need to be reconciled</i>, especially where the relationship between the parent and the practitioner is not (yet) strong</li> <li>• Multi-agency team working was <i>rarely reported</i> at the interface of adult health, adult social care and children’s social care services</li> <li>• Despite the development of a ‘good practice guide’ for ‘virtual’ team working, only one survey of implementation (of a protocol) could be found for adult mental health. A second study suggests that implementation is enhanced more by the <i>quality of the dialogue and relationships</i> than by the use of a dedicated ‘champion’ positioned at the service interfaces.</li> <li>• <i>‘Relational working’</i> was also central to the reported success of a court-based project for parents with learning disabilities</li> <li>• <i>Government audits</i> (Ofsted 2013) suggest that innovative models are more likely to be found where adult substance misuse intersects with child safeguarding. However, only three studies that described this were identified: two integrated family support projects and one court-based team.</li> <li>• <i>Speedy access</i> to services and the <i>intensive, structured and time-limited</i> nature of specialist joint team working are identified as common factors crucial to the success demonstrated, including some follow up of child outcomes</li> </ul>	
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Table 6: Effective interventions with children and families on the edge of care

**Treatment: attachment focused response to families and children on edge of care**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
NICE (2015) – Chapter 9	Yes.	RCTs	Yes	Yes.	Studies other than RCTs, involving ss aged 18+.  Any intervention that does not target at least one of the critical outcomes assessed.	Individual study results.	CI where available	Yes	Cost-effectiveness information, where available, is taken into account in the generation of statements and recommendations in clinical guidelines.

## Content

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
NICE (2015) – Chapter 9	Interventions aimed at promoting attachment in children and young people including those at the edge of care.	Improve parental outcomes including sensitivity, attunement, parenting skills; child outcomes, primarily attachment security; other child outcomes related to emotional wellbeing.	Trained and accredited health / mental health practitioners.	<p><b>Video feedback:</b> between very brief interventions of 3 sessions (90 – 180 mins each) to 7 – 21 sessions (60 mins.) Some models have sessions of 180 minutes.</p> <p><b>Parental sensitivity and behaviour training:</b> between very brief interventions of 4 – 6 sessions, (15 mins each) to 16 sessions (60 mins). Some interventions last 120 mins)</p> <p><b>Home visiting and parent-child psychotherapy:</b> 60 – 116 sessions, duration varied depending on family needs, approximately 60 mins.</p>	Parents and children and young people (aged 0–18 years) at risk of developing attachment difficulties and on the edge of care. Children on the edge of care are defined as those who are exposed to risk factors that are likely to bring them to the edge of care. Some home based work (VF, home visiting, some forms of parent training; others may be delivered in healthcare settings.	Signs of insecure or disorganised attachment.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
NICE (2015) – Chapter 9	11 RCTs of video feedback vs any comparison; 5 RCTs of parent-child psychotherapy vs any comparison; 9 RCTs of parental sensitivity and behaviour training vs any comparison; 23 RCTs of home visiting versus any comparison; 1 RCT Parent CBT vs any comparison; 2 RCTs of	Attachment (secure, insecure, disorganised) Parental sensitivity/responsiveness Emotional and behavioural functioning (that is, internalising and externalising behaviour)  Developmental status, specifically mental and motor development	<p><b>Evidence to support interventions aimed at increasing attachment security:</b></p> <p><b>Video feedback (VF):</b> VF for parents of children on the edge of care may improve sensitivity/responsiveness and secure attachment, and reduce insecure attachment.</p> <p>VF may reduce disorganised attachment, but confidence in the evidence is very low. The evidence was inconclusive for externalising and internalising behaviour. For sensitivity/responsiveness, the benefit</p>	<p><b>Children and adolescents “on the edge of care”:</b> NICE guidelines</p> <p><b>Preschool-age children with, or at risk of, attachment difficulties</b></p> <ul style="list-style-type: none"> <li>Offer a <b>home based video feedback programme</b> to the parents of preschool-age children on the edge of care. This should focus on increasing parental sensitive and attunement, be strengths based, consist of</li> </ul>

	<p>parent psychotherapy vs any comparison; 1 RCT of parent non directive counselling vs any comparison; 4 RCTs of home visiting versus any control; 2 RCTs of parent child psychotherapy versus control; 2 RCTs of video feedback versus control</p>	<p>Parental attitudes</p> <p>Adverse effect of any intervention</p>	<p>was maintained at follow-up. For secure attachment, assessed with continuous measures, there was a trend towards a benefit, but when assessed with dichotomous measures, findings were inconclusive. Insecure attachment was not measured at follow-up.</p> <p>One study included a long-term follow-up of 56 months and found a trend towards improvement in secure attachment supporting VF. There was no conclusive evidence for externalising behaviour and an effect was found in favour of the control for internalising behaviour. When compared with counselling, video feedback showed greater benefits in reducing maternal insensitivity. No harms were associated with this treatment. However, not all parents will accept this form of treatment.</p> <p>Lower quality or less conclusive evidence, still favouring interventions, for parent child psychotherapy vs controls on parental sensitivity and child attachment security; for parental sensitivity and behaviour training over control in terms of infant attachment security; mixed evidence on parental sensitivity. For parental sensitivity and behaviour training:</p> <p>Low to moderate quality evidence to support supporting PDBT over control in terms of sensitivity, responsiveness, and weaker evidence with a positive trend in terms of increasing secure attachment and reducing insecure attachment. Inconclusive evidence regarding internalising behaviour and parenting attitudes.</p> <p><b>Home visiting:</b> Moderate quality evidence from 12 studies finds HV is more effective than control in reducing child externalising behaviour, improving child mental and motor development and parenting outcomes; mixed evidence that HV more effective than controls in increasing parental sensitivity/responsiveness. Moderate evidence to</p>	<p>10 sessions (each lasting at least 60 minutes) over 3–4 months</p> <ul style="list-style-type: none"> <li>• If there is little improvement to parental sensitivity or the child's attachment after 10 sessions arrange a multi-agency review before going ahead with more sessions or other interventions.</li> <li>• If parents do not want to take part in a video feedback programme, offer <b>parental sensitivity and behaviour training</b>. Ensure this consists first of a single session with the parents followed by at least 5 (and up to 15) weekly or fortnightly parent–child sessions (lasting 60 minutes) over a 6-month period.</li> <li>• If parents do not want to take part in a video feedback programme or parental sensitivity and behaviour training, or, if there is little improvement and the multi-agency review concludes that further intervention is appropriate, consider a <b>home visiting programme to improve parenting skills</b> delivered by an appropriately-trained lay home visitor or a healthcare professional such as a nurse. Ensure home visiting programmes consist of 12 weekly or monthly sessions (lasting 30–90 minutes) over an 18-month period.</li> </ul> <p><b>Preschool-age children who have been or are at risk of being maltreated</b></p> <ul style="list-style-type: none"> <li>• Consider <b>parent–child psychotherapy</b> for parents who have maltreated or are at risk of maltreating their child to improve attachment difficulties, ensuring that safeguarding concerns are addressed. Ensure this 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.</li> </ul>
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		<p>show that it is more effective than control in improving parental responsiveness and control at 1 – 12 month follow up. Low quality evidence finds inconclusive results in terms of effectiveness of parenting and child measures at 4 and 7 year follow up.</p> <p><b>Psychotherapy:</b> low quality evidence that this is more effective than controls on sensitive /responsiveness; inconclusive in terms of reducing insecure attachment; incisive as to the effectiveness of psychotherapy compared to CBT on reducing insecure attachment.</p> <p><b>CBT:</b> Low quality evidence is inconclusive as to effectiveness of CBT vs control, psychotherapy or counselling in reducing insecure attachment at 14 months follow up.</p> <p><b>Evidence to support interventions for children and young people who have been maltreated:</b></p> <p><b>Video feedback:</b> Low quality studies find some support for VF wit pre-schoolers vs control in terms of parent sensitivity and responsive, increased attachment security, but is inconclusive with regard to internalising and externalising behaviour.</p> <p><b>Parent child psychotherapy (PCP):</b> Low quality evidence favouring PCP vs controls on preschool child attachment security, reducing maternal maladaptive representations. <b>PCP vs Home visiting (HV):</b> very low to low quality evidence finds mixed evidence that PCP more effective than HV on child attachment, but stronger evidence of improved maternal maladaptive representations</p> <p><b>Parental sensitivity and behaviour training: - Preschool and primary school aged children.</b> Low quality mixed on impact of PSBT over controls</p>	<p><b>Primary and secondary school-age children and young people with, or at risk of, attachment difficulties</b></p> <ul style="list-style-type: none"> <li>Consider <b>parental sensitivity and behaviour training</b> for parents of primary and secondary school-age children and young people to improve attachment difficulties, adapting the intervention for the age of the child or young person.</li> </ul> <p><b>Primary and secondary school-age children and young people who have been, or are at risk of being, maltreated</b></p> <ul style="list-style-type: none"> <li>Consider <b>trauma-focused cognitive behavioural therapy</b>, and other interventions in line with the NICE guideline on post-traumatic stress disorder.</li> <li>Consider <b>parental sensitivity and behaviour training for parents</b> at risk of maltreating their child to improve attachment difficulties, ensuring that safeguarding concerns are addressed and adapting the intervention to the age of the child.</li> </ul> <p><b>Older children who have been maltreated and show signs of trauma:</b> NICE recommends for older children standard evidence based treatments for trauma “such as cognitive behavioural therapy (CBT), interpersonal therapy, eye movement desensitisation and reprocessing, dialectical behaviour therapy, cognitive analytic therapy, family therapy that have a proven evidence base should be used for problems that they have already shown to be effective for in other populations of children.”</p>
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			<p>increasing parental sensitivity, reducing negative parenting behaviour, and on child externalising behaviour; no evidence for effectiveness on child internalising behaviour; low quality evidence favouring PSBT in terms of reducing reoccurrence of abuse.</p> <p><b>Trauma focused CBT vs parent child psychotherapy:</b>  <b>Primary and secondary school aged children:</b> Low quality evidence from a small number of studies favoured trauma based CBT over PCP in terms of parental sensitivity, reduced internalising behaviour. Inconclusive evidence on CBT vs PCP with respect to child externalising behaviour and with respect to parent and child measures at 6 to 12 month follow up.</p> <p><b>Approaches that are contraindicated:</b> NICE guidelines include reference to approaches: That are contraindicated because they are only ineffective but could cause harm to children. These include any form of therapy' that involves physical coercion or restraint, or aversive stimulation, including 'holding therapy'.</p>	
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**Interventions to strengthen attachment security in children at identified risk of maltreatment**

**Critical appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Barlow (2016)	Yes	Secondary and primary studies evaluating the effectiveness of interventions aimed at improving attachment and attachment-related outcomes on a universal, targeted or indicated basis  (Note: only indicated interventions reported here).	Yes, reported in detail the section of a larger rapid review summarised in this paper. <sup>134</sup>	In the original rapid review (Axford 2015) which this paper summarises	Interventions for parents of preterm infants; interventions that did not specifically aim at strengthening attachment or attachment related outcomes	Reported in detail in the original rapid review (Axford 2015) which this paper summarises	Narrative, but CIs reported in the rapid review (Axford 2015) which this paper summarises	Yes	Not specified

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Barlow (2016)	Universal, targeted and indicated intervention provided on an individual or group basis that was, and aimed at improving attachment status or attachment related outcomes. Studies included date from 2008 to 2015 only.  (Note: results presented in here pertain to children who have been maltreated)	Improving attachment or attachment related outcomes in children under age of 5.	Delivered by trained mental health practitioners.	There is considerable divergence in terms of the frequency and duration of interventions, with home visiting programmes such as MTB involving intensive visits over a prolonged period of time, and most other types of programme involving intensive work over brief periods of	Parent (primarily mother)-infant dyads. Delivered in home or clinic settings.	Interventions from very early infancy to child age 5 included in this review.

<sup>134</sup> Axford N *et al.* (2015) Rapid review to update evidence for the healthy child programme 0–5. London: Public Health England. <https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence>.

				time, typically a few months (e.g. Video-feedback and parent–infant psychotherapy)		
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## Results

Author (Year)	Included studies	Relevant Outcomes measured	Results	Author's conclusions
Barlow (2016)	Six systematic reviews and 11 randomised controlled Trials. Of these, one systematic review (Barlow 2015) and four RCTs focused specifically on children who had been maltreated or exposed to domestic violence or parental substance misuse.	Child attachment status Attachment related outcomes including parental availability, , sensitivity, responsiveness, verbal and non-verbal communication and child problem behaviours	<p>One systematic review of parent-infant psychotherapy (PIP).<sup>135</sup> The included studies targeted parents experiencing a range of problems, such as those who have maltreated their children and parents in prison. Meta-analyses based on data from two of the included studies indicated that parents who received PIP were more likely to have an infant who was rated as being securely attached to the parent; however, there were no significant differences in studies comparing outcomes of PIP with one of the other models of treatment (e.g. video feedback, counselling, CBT). One further RCT of PIP was identified<sup>136</sup>. This involved with parent–child dyads involving preschool age children (3–5 years) who had experienced multiple traumatic and stressful life events found significant improvements favouring the intervention group for child PTSD (5% cf. 53%), depression, co-occurring diagnoses and behaviour, maternal PTSD and depression.</p> <p>One RCT<sup>137</sup> of a home-delivered programme using video feedback with maltreating parents found significant improvements for the intervention group in parental sensitivity; child attachment security including shift from disorganised to organised attachment. Older children in the intervention group showed lower levels of internalising and externalising problems</p>	Parent–infant psychotherapy, video feedback and mentalisation based programmes appear to be promising approaches to improving attachment in a range of high-risk infants, including those with maltreating parents. These interventions should be provided by practitioners working in child and adolescent mental health services to parents and children under 5 years of age, where children are experiencing problems that may be underpinned by attachment difficulties. There is limited evidence that interventions of longer duration are more effective than brief, intensive ones (Barlow 2015).

<sup>135</sup> Barlow, J *et al* (2015). Parent-infant psychotherapy for improving parental and infant mental health. *Cochrane Database of Systematic Reviews*, 1, CD010534.

<sup>136</sup> Ghosh S *et al.* (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse & Neglect*, 35, 504–513.

<sup>137</sup> Moss, E, *et al* (2011). Efficacy of a home-visiting intervention aimed at improving maternal sensitivity, child attachment, and behavioral outcomes for maltreated children: A randomized control trial. *Development and Psychopathology*, 23, 195–210.

			<p>One RCT <sup>138</sup>evaluated the effectiveness of a mentalisation-based programme known as the Mothers and Toddlers Programme (MTP), which combines individual therapy with standard outpatient substance abuse treatment programmes. The trial found, for the for the MTP group, moderate improvements in reflective functioning and slightly higher scores for coherence, sensitivity and quality of representation improved caregiving behaviour for MTP mothers, and improvements in depression and global distress post intervention. Mean reflective functioning score was maintained but reduced in the MTP group at follow up, a slightly higher quality of maternal representation for the MTP group and moderately higher mean scores for child communication. Effects for maternal depression were not sustained.</p> <p>One RCT examined the effectiveness of Minding the Baby (MTB), a mentalisation-based home visiting intervention for young first time mothers experiencing serious problems including violent relationships and depression in the perinatal period. <sup>139140</sup> 11% of the mothers in the sample had child protection concerns. Significantly higher infant security was reported in MTB vs intervention infants. MBT mothers had fewer instances of rapid subsequent childbearing and a trend towards fewer open cases with child protection services. There were no significant differences between groups in maternal reflective functioning, depression or psychological distress.</p>	
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<sup>138</sup> Suchman, N *et al* (2011). The mothers and toddlers program, an attachment-based parenting intervention for substance- using women: Results at 6-week follow-up in a randomized clinical pilot. *Infant mental health Journal*, 32, 427–449.

<sup>139</sup> Sadler, L.S *et al* (2013). Minding the baby: Enhancing reflectiveness to improve early health and relationship outcomes in an interdisciplinary home-visiting program. *Infant Mental Health Journal*, 34, 391–405.

<sup>140</sup>MTB is currently being evaluated in the UK in a trial conducted by the NSPCC.

### ***Interventions for the cessation of child maltreatment***

**Note:** Ward (2014) summarises evidence on a number of different subjects relating to parental capacity to change in families where there are significant child protection concerns. This table reports on findings related to interventions with children on the 'edge of care'. Other subjects such as client provider relationship, assessment and motivation to change are outlined in separate tables.

#### **Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Ward <sup>141</sup> (2014)	Yes	Papers based on empirical data. Priority given to systematic reviews and meta analyses over individual papers.  Reviewers did not otherwise apply rigid inclusion/exclusion criteria.	Yes	Yes	Rigid inclusion/ exclusion criteria "were not applied as it was important to gain an overview of the range of literature available."	Narrative	Narrative	Yes	Not discussed in this section of the paper.

#### **Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Ward (2014)	Parent or family focused interventions in families where child maltreatment has been identified.	Reduced child maltreatment, improved parenting, improved family functioning.	Not specified in detail but most tertiary interventions are delivered by trained professionals.	A dynamic process of varying length of time.	Families where one or more children are on the "edge of care."	When children are on the edge of care, and when decisions are made about looked after children returning to family care.

<sup>141</sup> Includes some cost benefit analyses.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Ward (2014)	<p>Experimental studies of parent or whole family interventions to improve family functioning and reduce child maltreatment in families where this has already occurred.</p> <p>The precise number of included studies in this or other sections is not specified in this narrative report</p>	Reduction of child maltreatment; parenting; other adult, child and family outcomes.	<p>Intensive Family Preservation Services (IFPS) have been shown to improve family functioning. However changes have not been maintained in the long term with families with entrenched and complex problems. IFPS delay children's entry to care and reduce the time they spend away from home, but they do not reduce the likelihood of them becoming looked after.</p> <p>Evidence to support Parents under Pressure (PUP) programme.</p> <p>Evidence to support enhanced versions of Incredible Years and PCIT in terms of reduction of child maltreatment. However, standard parent training programmes which have been shown to be effective in the general population (e.g. Triple P) have limited effectiveness in families with severe and chronic difficulties, even when adapted for this population. Evidence to support level 5/enhanced version of Triple P is inconclusive.</p> <p>Intensive multi-faceted integrated interventions for families with complex needs are more effective than routine services, but should be dovetailed with other services to form a child protection plan that can offer different levels of support as required.</p>	<p>Intensive multi-faceted integrated interventions for families with complex needs are recommended but need to be dovetailed with other services to form a child protection plan that can offer different levels of support as required.</p> <p>Intensive Family Preservation Services (IFPS) are of value to families in emergency/crisis but not recommended for children at the edge of care in families with chronic difficulties.</p> <p>Enhanced versions of standard parenting programmes can be effective with families at risk but are not recommended as stand-alone interventions with families / children on the edge of care.</p>

**Solutions Focused Brief Therapy (SFBT)**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Woods (2011)	Yes	Range of quantitative and qualitative study designs.	Yes	Yes	Primary study reporting on the effectiveness of SFBT with/without cost effectiveness and/or child protection implications of SFBT.  Sample(s) including children and young people (0-18) and/or their families.  Studies that were a review or meta-analysis, rather than a primary study, and met the rest of the inclusion criteria, were not included in the review.	Individual study results	Cis where data available.	Yes	Five studies report on the cost of the intervention, but no study reports on cost benefit as such. Reviewers' proxy cost estimates suggest that group delivered SFBT, where possible, may be more cost effective than individually delivered SFBT.

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Woods (2011)	Solutions Focused Brief Therapy	Child emotional and behavioural adjustment	Therapists trained or in training.	Brief – not more than 10 sessions maximum.	Children with emotional and behavioural problems and families; review includes children outside family care or with relatives in prison. Delivered in groups or one to one.	Not specified.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Woods (2011)	<p>38 'best evidence' studies selected from 84 relevant papers.</p> <p>RCTs, non-randomised controlled studies, pre-and post-intervention studies, qualitative and case studies.</p> <p>Of the 38 included studies only 3 focus directly on child protection issues "though almost all studies are relevant to the category of 'children in need'." Of these, one is a Quasi-experimental study involving children who have experienced maltreatment, one a single case study involving maltreatment and delinquency, and one a case study involving exposure to domestic violence.</p>	<p>Main relevant outcomes measured are child internalising and externalising behaviours; parenting; child maltreatment.</p>	<p>Of three studies which focus directly upon child protection all reported improvements in child internalising and externalising behavioural problems. However, two are case studies only. A second larger scale study offers promising results but; however, SFBT was used in combination with other approaches. Some that SFBT can contribute to reducing recurrence of child maltreatment.</p> <p>The majority of best evidence from this review shows improvements following SFBT intervention in: children's 'externalising' behaviour problems (for example, aggression, co-operation, truancy) ; children's 'internalising' problems (for example, shyness, anxiety, depression, self-esteem, self-efficacy)</p> <p>The authors do not provide any detail about the relative contribution of the SFBT element within their framework or account for why their approach was unsuccessful in some cases</p>	<p>There is evidence to support SBFT to improve children's internalising and externalising problem behaviour. Evidence in relation to children on the edge of care/maltreated children shows promise but is very limited When SBFT is offered in conjunction with other services and supports, it is difficult to determine the impact of this approach.</p> <p>There is considerable variation within particular types of problems experienced by children and families, and that many children and families may evidence degrees of multiple problems and differing circumstances. Why SBFT is effective with some children and families and not others is not clear.</p> <p>These factors mean that a social worker's individual case is not likely to fit perfectly with the effectiveness research with specific types of child/ family problems. In relation to social work practice, Munro (2011)<sup>142</sup> points out that evidence-based practice is not simply a case of taking an intervention off the shelf and applying it to a child and family. Therefore, research evidence on the effectiveness of an intervention such as SFBT with particular types of child and family problems, provides a starting point, rather than the final word, for effective and safe practice.</p> <p>Therefore, further research is needed into the effectiveness of SFBT in cases where children are considered to be suffering, or likely to suffer, significant harm.</p>

<sup>142</sup> Munro, E. (2011). *The Munro Review of Child Protection (Final Report): a child centred system*. Norwich: The Stationery Office.

**Treatment/prevention of reoccurrence of child abuse and neglect – engaging fathers**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Outcomes assessed	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Smith (2012)	Yes	Range of study designs.	Yes	Yes	Original research studies describing an intervention for the primary prevention of child maltreatment for children under the age of five. Included studies had to include at least one father.	Parental attitudes, knowledge and beliefs, parenting stress, parental mental health, home safety, child abuse risks, child behaviour	Individual study results	P values/statistical significance.	Yes	Not analysed in this paper.

**Content**

Author (Year)	Intervention reviewed	Intervention aim of included studies	Intervention delivery	Intervention frequency and duration of included studies	Intervention target and setting	Timing
Smith (2012)	Interventions involving fathers and aimed at preventing occurrence or reoccurrence of abuse.  Data has been extracted for 5 studies for highest risk groups only: fathers who had been court mandated, referred by child welfare, in methadone treatment, or in prison). 4 out of 5 studies involved both fathers and mothers but reported on fathers only.	To engage fathers in prevention/cessation of maltreatment of children under age of 5.	Trained professionals.	<i>Prison:</i> DADS Family Project - four three hour sessions.  <i>Methadone treatment:</i> Parents Under Pressure 10 -12 weeks home based, 2 weeks clinic based.  <i>Court mandated:</i> Clinic based group programme, media based; 13 weeks.  <i>Child welfare referred:</i> 8 week clinic based parent training programme. Home based 24 week programme.	4/5 interventions included both fathers and mothers, with fathers constituting a small minority (5% - 16%) of the sample. Prison intervention involved fathers only.  Prison, home, clinic settings.	Not specified.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Smith (2012)	<p><i>Prison:</i> 1 single group pre-post test</p> <p><i>Methadone treatment:</i> 1 RCT</p> <p><i>Court mandated:</i> 1 single group pre post.</p> <p><i>Child welfare referred:</i> 2 single group pre post.</p>	Reduction of paternal risk factors for child maltreatment.	<p><i>Prison:</i> Parenting attitudes: Post intervention significant improvement in the following subscales: permitting self-expression, avoiding harsh punishment and no physical punishment. No improvement in: encouraging verbalisation, fostering independence, avoiding strictness, encouraging emotional expression, or orienting to change. Men in the video training group had more significant pre-post changes compared to men in the in-person training group.</p> <p><i>Methadone treatment:</i> Parenting stress: Significant reductions in parenting stress for the PUP group only Child abuse potential: Significant reductions for the clinic and PUP intervention groups Child behaviour: Significantly improved child behaviour in the PUP group only Parental substance abuse: Significant reductions in methadone dose for the PUP group only</p> <p><i>Court mandated:</i> Parenting: 1. Statistically significant increase post-test in cooperative parenting styles (<math>p &lt; 0.01</math>) 2. Statistically significant decrease post-test in punitive parenting styles (<math>p &lt; 0.01</math>) 3. Statistically significant decrease post-test in blaming the child (<math>p &lt; 0.01</math>) 4. No statistically significant difference in the number of reasons for the child's behaviour, ratings of intentionality, or perception of how bad the child was regarded</p> <p><i>Child welfare referred:</i> Child healthcare: Post-intervention scores improved for knowledge of self-treating, when to call a doctor and when to use emergency department services Home safety: Mean reductions in household hazards: 78% for maltreating group and 70% for at-risk group Parenting: 1. Significant improvement in positive parenting in the maltreating group 2. Significant improvement in planned activities techniques in maltreating group</p> <p>1. Post intervention significant decrease in PSI/SF = 8.2 (<math>p &lt; 0.001</math>) 2. Significant increase in total NCAST = 3.70 points (<math>p &lt; 0.001</math>) Infant's home environment: Significant improvement in HOME scores by 1.86 points (<math>p &lt; 0.001</math>)</p>	<p>Few empirically studied primary programmes for child maltreatment include fathers.</p> <p>Included programmes typically sought to reduce child maltreatment by focusing on improving parental functioning and parenting capacity through parental education. However, the effectiveness of most included programmes in reducing paternal risk factors for child abuse and neglect is uncertain because most programmes did not separate the results for mothers compared to fathers. This was most likely because the small numbers of fathers in each programme precluded drawing meaningful statistical associations. Therefore, (with the exception of the prison based programme) it is difficult to specifically determine whether fathers benefited from participation in these programmes, or whether a different focus and content may be more appropriate.</p> <p>Future programmes should determine how to effectively recruit fathers and actively engage their participation, provide programme content relevant to fathers, and conduct interventions at times and locations convenient to fathers.</p>

**Interventions following physical abuse**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Montgomery (2009)	Yes	Published and unpublished studies "of varying quality and rigour."	Yes	Yes	Child focused, parent focused and family focused interventions for children who have been physically abused.  Studies with no language or geographical restrictions, investigating child- focused, parent-focused, or family-focused interventions for children who have experienced physical abuse.  Evidence of varying quality included so as to capture a complete picture of what is known in this field.	Narrative	Narrative	Yes	Cost benefit analysis possible in relation to one programme for children on the edge of care - Homebuilders. Evidence of cost-benefits.

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Montgomery (2009)	Child focused, parent focused and family focused interventions for children who have been physically abused.  (Note: interventions for children in foster or residential care are not included in this table)	End reoccurrence of physical abuse of child/ren.	Varies	Not specified in detail	Children who had been physically abused; physically abusive parents; families. Settings varied from home, community settings, school; also residential care settings.	Not specified

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Montgomery (2009)	18 studies, including RCTs, quasi randomised controlled trials, non-randomised controlled trials, or cohort studies investigating the effects of an intervention over time.	Reoccurrence of abuse. A range of parent and child outcomes, including child mental health, parent child interactions, parental functioning, child abuse potential.	<ul style="list-style-type: none"> <li>• <b>The most consistent and promising evidence supported the effectiveness of parenting interventions</b> such as Webster-Stratton's Incredible Years and Parent-Child Interaction Therapy for improving parent-child interactions and child mental health outcomes. One study of <b>Parent-Child Interaction Therapy</b> measured recurrence of abuse, showing positive results.</li> <li>• A <b>therapeutic preschool intervention (Childhaven)</b> that incorporated psychological services showed a reduction in antisocial behaviour in a long-term follow-up of 12 years.</li> <li>• Family <b>therapy</b> may be effective for improving parental discipline, reducing parent-child conflict, and child abuse potential but was only compared to other types of family therapy or parent-child CBT, so the size of the effects is unclear.</li> </ul> <p>• In relation to children who have been physically abused, several interventions including home visiting, psychodrama, therapeutic day treatment, individual child psychotherapy, and art therapy do not have sufficient evidence to support their effectiveness due to a lack of well-conducted studies and limited outcome measures.</p> <p>Residential treatment and play therapy were not found to be effective, with comparison treatments showing better outcomes.</p> <p>There is still a need for further research to elucidate the role that many child and family-focused interventions might play.</p>	<ul style="list-style-type: none"> <li>• There are a number of well-designed studies investigating the effectiveness of interventions for children who have experienced physical abuse. However, many interventions that are currently used in practice have not been well-studied.</li> <li>• More research is needed to investigate the effectiveness of the wide range interventions that are currently being provided in this population, using well-designed and conducted randomised controlled trials.</li> </ul>

**Treating parents who perpetrate child physical abuse**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Oliver (2009)	Yes	Case studies, pre-post-test involving a single group or two groups, single group post-test, RCTs.	Yes	Yes	Empirical research involving an intervention targeting families in which abuse had occurred.  Articles were excluded if: <ul style="list-style-type: none"> <li>• intervention occurred outside the United States;</li> <li>• primary focus was on adoption;</li> <li>• primary target was either sexual abuse or substance abuse;</li> <li>• primary focus of the intervention was on providing treatment for the abuse victim rather than the perpetrator;</li> <li>• intervention was not described;</li> <li>• study was not empirical;</li> <li>• Or the piece was either a book or dissertation.</li> </ul>	Individual study results	Possibly; all included studies selected took place in the US.	Yes	Not analysed in this paper.

## Content

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Oliver (2009)	Treatments or interventions with perpetrators of child physical abuse.	Prevent reoccurrence of physical abuse	'Educators'; primarily health professionals.	<i>Home visiting</i> : two papers included studies lasting approximately 24 weeks, with 2 hour sessions. <i>Group therapy</i> (multifamily and traditional therapy): frequency and duration not specified. <i>Video based training</i> : frequency and duration not specified. <i>Intensive family preservation services outside the home</i> , including therapeutic groups (e.g. Florida Infant Mental Health Pilot Programme), Parent child Interaction therapy, and Parent Child Attunement Therapy. These last up to 25 sessions. Duration of each session not specified.	Predominantly the family unit or parent-child dyad. 2 articles described interventions for caregiver alone.  Home and community (e.g. Sure Start centre) and possibly other e.g. healthcare settings.	Not specified, but intensive interventions are offered when maltreatment or neglect have been identified.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Oliver (2009)	3 case studies, 2 RCTs, 4 single group pre and post-test studies, 1 2-group pre-post-test, 1 post-test only.  <i>Home visiting</i> : 2 interventions described in 6 studies. <i>Group therapy</i> – 2 studies. <i>Video based training</i> : 2 studies. <i>Intensive family preservation services outside the home</i> – 5 studies.	<b>Parenting</b> : parenting capacity, emotional availability, parent child interaction, parenting pressure, parent social support  <b>Child behaviour</b> ; child mental health measures  Child abuse potential or reoccurrence  Home environment	<b>Home visiting</b> : 2 interventions described in 6 studies. All components were found to be effective in achieving positive outcomes in one intervention (Project Safe Care). Second intervention reported improvements in parenting attitudes and practices, with improvements in communication, conduct, and response to discipline. Caregivers also expressed increased satisfaction with children's friends and with children.  <b>Video based training</b> : Focused on home safety. One study found sustained improvements 1.5 years follow up and one slight improvements post training in parents in knowledge and practices around home safety.  <b>Group therapy</b> – 2 of therapeutic groups in community settings (e.g. Head Start). Both reported increased social support and one reported lower levels of stress post intervention	Very limited empirical research is available evaluating the effectiveness of current interventions used with maltreating families. <ul style="list-style-type: none"> <li>• Parent-child dyads or entire families are popular intervention targets.</li> <li>• Addressing lack of caregiver social support and providing case management activities may improve participation levels and effectiveness of interventions.</li> <li>• High attrition rates and low levels of adult male caregiver participation are common limitations in the evidence.</li> <li>• Maltreating parents appear to frequently minimize the problems they are having with their children.</li> </ul>

		<p><b><i>Intensive family preservation services outside the home</i></b></p> <p>– This includes the two group therapy programmes in community settings (above). The three additional studies report improvements in measures of parenting/parent child interaction. One (Florida parent Infant Mental Health Program) provides more detailed evidence of increased parental emotional responsiveness, attunement and positive discipline.</p> <p>One study found that external stressors impacted on effect on parent/child dyad.</p> <p>High attrition rates across all studies; this was true even in court mandated samples. Therapeutic groups in Head Start Centres that provided child care had lower levels of unplanned termination.</p> <p>Low levels of father engagement are recurring challenges.</p> <p>Some articles indicated that parents with a history of child abuse may have minimised problems in self-assessments given as pre-test measures, leaving less room for improvement which would result in an inaccurate measurement of the intervention effect.</p>	<ul style="list-style-type: none"> <li>• Few interventions directly address caregivers’ psychological needs as an intervention goal.</li> </ul>
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**Amelioration and treatment of child physical abuse and neglect**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Barlow (2006a)	Yes	Systematic reviews	Yes	Yes	Systematic reviews of treatments or interventions with perpetrators of child physical abuse and neglect  Reviews excluded if there was no evidence of a systematic and/or comprehensive search or because data from the included studies were not presented.	Individual study results	CIs	Yes. Some of these interventions could be implemented as part of existing services for children in the UK and elsewhere	There is as yet limited evidence on cost effectiveness but more analysis is needed.

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Barlow (2006a)	Treatments or interventions with perpetrators of child physical abuse and neglect, including: home visiting, group therapy, video-based training and intensive family preservation services outside the home.	Prevent reoccurrence of physical abuse and neglect	Trained professionals. Some media based programmes included in the review	<i>Home visiting</i> : two papers included studies lasting approximately 24 weeks, with 2 hour sessions. <i>Group therapy</i> (multifamily and traditional therapy): frequency and duration not specified. <i>Video based training</i> : frequency and duration not specified. <i>Intensive family preservation services outside the home</i> , including therapeutic groups (e.g. Florida Infant Mental Health Pilot Programme), Parent child Interaction therapy, and Parent Child Attunement Therapy. These last up to 25 sessions. Duration of each session not specified.	Predominantly the family unit or parent-child dyad. 2 articles described interventions for caregiver alone.  Home and community (e.g. Sure Start centre) and possibly other e.g. healthcare settings.	Not specified, but intensive interventions are offered when maltreatment or neglect have been identified.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Barlow (2006a)	15 systematic reviews that covered a range of interventions/services, including 5 reviews focused on indicated treatment / interventions in families where children were at risk of removal or where abuse had occurred. Interventions included including home visiting, parenting programmes, multi-component interventions, intensive family preservation services, family-focused casework and multi-systemic family therapy	<p><b>Parenting:</b> risk factors associated with child abuse and neglect</p> <p><b>Child measures:</b> child behaviour, cognitive processes, personality (self-report and parent report)</p> <p><b>Family functioning</b></p> <p><b>Out of home placement</b></p> <p><b>Verified abuse and neglect</b></p>	<p><b>Parenting programmes:</b> 1 review of parenting programmes for parents with a history of abuse. Some, limited evidence that some parenting programmes (particularly the cognitive behavioural, parent-child interaction therapy multi-systemic family therapy and Webster-Stratton programmes) could be effective in improving some outcomes associated with physically abusive parenting, such as parenting attitudes and behaviour.</p> <p><b>Intensive family preservation services</b> 2 reviews found no evidence to support the use of IFPS in reducing out-of-home placements.</p> <p>Other reviews reported significant improvements in family functioning, parental disposition, children's performance, delinquency, relationships with peers, child symptomatology and maltreatment after the intervention (Dagenais <i>et al</i>, 2004)<sup>143</sup>, improved parental reports of child care (ES: 1.0) and children's conduct (ES: 0.5) (Edgeworth &amp; Carr, 1999)<sup>144</sup>, and an overall improvement on a composite measure of outcome (ES: 0.38) (MacLeod &amp; Nelson, 2000).<sup>145</sup></p> <p><b>Range of behavioural, nonbehavioural and other psychological treatments for child maltreatment including sexual abuse</b> One review included five studies of a range of family-focused interventions including a social network intervention programme (comprising social skills training; self-help support group membership; support from volunteers and</p>	<ul style="list-style-type: none"> <li>• There is considerable scope for intervening with parents who have abused or neglected their children with a view to improving outcomes such as parenting practices.</li> <li>• Overall, the most effective interventions (both targeted and indicated) comprised multiple components that were flexible and capable of addressing the different facets of abusive and neglectful parenting.</li> <li>• Effective parent-focused interventions included home visiting and behavioural parent-training combined with cognitive behavioural therapy to help regulate negative emotional states.</li> <li>• Other potentially helpful family-focused interventions include multi-systemic family therapy programmes, family-focused casework and intensive family preservation services.</li> <li>• There is considerable scope for the routine use of some of the above interventions as part of services to both prevent and treat physical abuse and neglect in the UK and other western developed countries.</li> </ul>

<sup>143</sup> Dagenais, C et al. (2004) Impact of intensive family support programs: a synthesis of evaluation studies. *Children and Youth Services Review* 26, 249–263

<sup>144</sup> Edgeworth J & Carr A (2000) Child abuse. In: A Carr (Ed) *What Works with Children and Adolescents? A critical review of psychological interventions with children, adolescents and their families*. London: Brunner Routledge.

<sup>145</sup> MacLeod J & Nelson G (2000) Programs for the promotion of family wellness and the prevention of child maltreatment: a meta-analytic review. *Child Abuse and Neglect* 24 (9) 1127–1149.

			<p>neighbourhood helpers) and family focused casework (comprising behavioural family assessment and feedback followed by family-focused problem-solving).</p> <p>The results showed that these interventions were all effective in improving different aspects of family functioning that are related to child abuse and neglect, such as child management skills and skills to regulate negative emotional states.</p> <p>Combined effect sizes found that clients treated appeared to be functioning better than 71% of non-treated counterparts. Higher effects obtained for self and parent ratings rather than objective ratings</p> <p><b><i>Social support and media based interventions.</i></b> 1 review evaluated the effectiveness of these approaches to preventing and ameliorating abuse and neglect. The results of a composite measure of outcome (including factors such as parenting attitudes and behaviour and the home environment) showed a medium effect for social support/mutual aid (ES: 0.61) but no evidence of effectiveness for media-based interventions (ES: 0.13).</p>	
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**Interventions for perpetrators of physical abuse**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Barlow (2006b)	Yes	RCTs	Yes	Yes	<p>Studies were eligible for inclusion in the review if intervention was provided directly to parents of children aged 0 - 19 years. Programmes had to have targeted parents who have a history of physical abuse or neglect</p> <p>Multifaceted programmes in which it is not possible to assess the independent effect of the parenting programme and intensive home visiting programmes were excluded.</p>	Individual study results	CIs	Yes.	There is as yet limited evidence on cost effectiveness but more analysis is needed.

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Barlow (2006b)	Brief (i.e. between 6 and 30 weeks) standardised individual or group-based parenting programmes provided on a targeted basis (i.e. to parents with a history of abuse or at high-risk of abuse) with a view to preventing the (re)occurrence of child maltreatment. Included standard parenting programmes modified to meet the specific needs of high-risk parents	Prevent reoccurrence of physical abuse.	Trained professionals.	6 – 30 weeks.	Physically abusive parents in home or community settings.	Not specified, but intensive interventions are offered when maltreatment or neglect have been identified.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Barlow (2006b)	<p>7 RCTs of indicated treatment / interventions in families where abuse had occurred.</p> <p>Interventions included including home visiting, parenting programmes, multi-component interventions, intensive family preservation services, family-focused casework and multi-systemic family therapy</p>	<p><b>Reported abuse</b> (e.g. the incidence of child abuse, number of injuries, or reported physical abuse).</p> <p><b>Out of home placements, change of primary caregiver</b></p> <p><b>Factors predictive or associated with abuse.</b></p> <p>These measured a range of aspects of parenting (e.g. parental child management, discipline practices, child abuse potential and mental health), child health (e.g. Emotional and behavioural adjustment) and family functioning.</p>	<p><b>Objective measures of child abuse (3 studies).</b> Findings provide evidence to support Parent Child Interaction Therapy (PCIT) on measures of abuse. One study (Chaffin 2004) found that significantly fewer intervention families (36%) had a re-report of physical abuse compared with a control group (49%) (Or another extended PCIT programme - 36%) (<math>p=.02</math>). Results favouring PCIT were reported on other related measures including the Child Abuse Potential Inventory (CAPI) (Terao, 1999). These results are, however, confounded by the differences in the ways that PCIT and control group intervention were delivered (one to one versus group based).</p> <p><b>Parenting, child and family measures predictive of or associated with abusive parenting (4 studies).</b> Most of the results favoured the intervention group, but many failed to achieve statistical significance. Effect sizes tend to be medium to low.</p> <p>However, those with effect sizes in the region of 0.3 - 0.4 favoured programmes that had either additional components or that were based on the use of theoretical approaches specifically aimed at addressing problems associated with abusive parenting.</p> <p>Thus, results suggest that use of child management techniques on their own i.e. without changing other aspects of the parents behaviour such as mood or stress, are less effective in terms of the child's wellbeing. Overall, comparative studies suggest that parenting programmes that incorporate additional components aimed specifically at addressing problems associated with abusive parenting (e.g. excessive parental anger, misattributions, and poor parent-child interaction) may be more effective than parenting programmes that do not incorporate these components.</p>	<p>The lack of objective assessments of abuse such as reports of child abuse, children on the child protection register etc.) means that there is little evidence to support parenting programmes for treatment of child physical abuse. There is some limited evidence to support PCIT.</p> <p>There is, however, some, limited evidence to show that some parenting programmes may be effective in improving some outcomes that are <i>associated</i> with physically abusive parenting.</p> <p>There is an urgent need for further rigorous evaluation of the effectiveness of parenting programmes that are specifically designed to treat physical abuse and neglect, either independently or as part of broader packages of care.</p>

**Intensive Family Preservation Programmes**

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Al (2012)	Yes	Experimental studies that included a control group.	Yes	Yes	Experimental studies involving a control group, evaluating (an) intensive family preservation program(s).  Studies were excluded if comparing two nearly identical interventions (E.g. the same intervention in two locations); if testing incremental efficacy of experimental vs established treatment; if the contained insufficient statistical information for calculating effect size.	Meta-analysis	CIs	Not certain	Not analysed in this paper. However, there is evidence on the cost effectiveness of IFPPs, in the UK (see section 5)

## Content

Author (Year)	Intervention reviewed	Intervention aim	Outcomes measured	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Al (2012)	Intensive family preservation programmes for children on the edge of care	To prevent need to place child in out of home care	Prevention of out-of-home placement.  Family functioning (e.g. parenting stress, parent-child interaction, or an integral measure), child behaviour problems or social support.	Trained mental health professionals	Most interventions are based on Homebuilders model. This is based in crisis theory, and involves intensive, 24 hour availability of practitioners for a 'few weeks'. Intervention has multiple strands including material support.	Clients home	Point at which children are at imminent risk of placement in state-funded care

## Results

Author (Year)	Included studies	Results	Author's conclusions
Al (2012)	20 studies. 13 RCTs and 7 other experimental studies with control group. 10 studies evaluated interventions based on the Homebuilders model.	<p>Meta-analysis of 20 studies shows that a medium sized positive effect on family functioning (<math>d = .486</math>) but were generally not effective in preventing out of home placement. The programme appears effective for multi-problem families but not for families experiencing abuse and neglect.</p> <p>Effect of out of home placement was moderated by client characteristics. It was more effective for younger children, and for boys. Effects were also moderated by parent age, number of children in the family, single parenthood, non-white ethnicity; workers caseload; but not by adherence to the Homebuilders design or duration of the intervention.</p>	<p>Meta-analysis showed intensive family preservation programs to be effective in improving family functioning. However, which factors moderate the effects of family preservation programs on family functioning could not be demonstrated.</p> <p>With respect to prevention of out-home placement, intensive family preservation programs were generally not effective, and sometimes even counterproductive for at least part of the target group.</p> <p>Although a broad range of 'at risk' families are served by these interventions, it seems that only a small group within that spectrum of risks benefits in the intended way. The intervention is least effective with families with identified abuse and neglect.</p> <p>This raises the question whether families that are targeted by intensive family preservation programs, those with a child on the 'edge of care', should be selected for this kind of treatment. It may be necessary to not only focus on placement prevention, but also on other relevant outcomes, for example crisis change, safety change and improvement of family functioning.</p> <p>If the focus is shifted from families with a child at the 'edge of care' to families in crisis out of home (respite) care can be part of the intervention for some of the participating families.</p>

**Cognitive-behavioural (CBT) approaches to treatment of child sexual abuse <sup>146</sup>**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Macdonald (2012)	Yes	Controlled trials with a randomised or quasi randomised design, comparing cognitive behaviour therapy versus treatment as usual, with or without placebo control, and studies comparing one intervention versus control were included.	Yes	Yes	Behavioural or cognitive behavioural interventions, involving children and adolescents under age 18, with or without parents.  Studies were excluded if not randomised or quasi-randomised or compared cognitive behavioural therapy with another experimental treatment.	Meta-analysis	CIs	Yes	Not analysed in this paper.

<sup>146</sup> Note: a separate Cochrane review of RCTs for psychoanalytic/psychodynamic treatment of CSA has been undertaken (Parker & Turner 2013). No experimental studies were identified that met the inclusion criteria. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008162.pub2/abstract>

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Macdonald (2012)	Interventions described by the authors as behavioural or cognitive-behavioural or that described the use of cognitive-behavioural interventions.  Treatments may or may not include parents.	To improve child emotional wellbeing, reducing depression, anxiety and symptoms associated with PTSD; reduce externalising and internalising behavioural problems; Improve capacity of parents to support the child and manage behaviour.	Trained clinicians	Not specified in all cases but generally between 6 and 20 sessions.	Children or young people who have been sexually abused and non-offending caregivers. Individual and group settings.	Following identification.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Macdonald (2012)	Ten trials, including 847 participants.	<p><b>A. Psychological functioning of child</b> (primary outcomes)</p> <p>i) Depression</p> <p>ii) Post-traumatic stress disorder</p> <p>iii) Anxiety</p> <p><b>B. Child Behaviour problems</b></p> <p>i) Sexualised behaviour</p> <p>ii) Externalising behaviour (e.g. aggression, 'acting out')</p> <p><b>C. Future offending behaviour</b></p> <p>i) Of child when adolescent and/or adult.</p> <p><b>D. Parental skills and knowledge</b></p> <p>i) Of child sexual abuse and its (possible) consequences</p> <p>ii) Belief in their child's story</p> <p>iii) Accurate attributions for their child's behaviour or psychological problems</p> <p>iv) Behaviour management skills approaches in treating the immediate and longer-term sequelae of child sexual abuse.</p>	<p><b>Psychological functioning of the child</b></p> <p><b>i) Depression</b></p> <p>Seven studies looked at the impact of intervention on depression in children using the CDI. Data from five studies were available in a form that could be combined in a meta-analysis. These five studies yielded an average decrease of 1.8 points on the Child Depression Inventory immediately after intervention (95% CI decrease of 4.0 to increase of 0.4; I2 inconsistency statistic = 47%; P value for heterogeneity 0.11), and three of these studies sustained an average decrease of 1.9 points (95% CI decrease of 3.9 to increase of 0.1; I2 = 0%; P = 0.7) after at least one year.</p> <p><b>ii) Post-traumatic stress disorder</b></p> <p>Six studies examined the impact of CBT on post-traumatic stress using a variety of scales. These studies yielded an average decrease of 0.43 standard deviations on various child post-traumatic stress disorder scales (95% CI 0.16 to 0.69; I2 = 40%; P value for heterogeneity 0.14) immediately after treatment, and two of these sustained a decrease of 0.50 standard deviations (95% CI 0.17 to 0.87) after at least one year.</p> <p><b>iii) Anxiety</b></p> <p>Six studies examined the impact of CBT on anxiety. Five studies, using two scales, yielded an average decrease of 0.21 standard deviations on various child anxiety scales (95% CI 0.02 to 0.40; I2 = 0%; P value for heterogeneity 0.89) immediately after treatment, and two of these sustained a decrease of 0.28 standard deviations (95% CI decrease of 0.61 to increase of 0.04) after at least one year.</p> <p><b>B. Child Behaviour problems</b></p> <p><b>i) Sexualised behaviour</b></p> <p>Five studies provided conflicting evidence on the effectiveness of CBT in the domain of child behaviour problems. Two studies observed increases of 4.7 and 1.7 points and three observed</p>	<p>Cognitive-behavioural approaches, particularly those that are trauma-focused, merit consideration as a treatment of choice for sexually abused children who are experiencing adverse consequences of that abuse.</p> <p>In particular, trauma-focussed cognitive-behavioural approaches are already recommended by some as part of a flexible, staged response to this problem in a number of jurisdictions. In practice, however, they are not often widely available.</p> <p>However, the evidence is more equivocal than some reviewers would suggest, including those who have themselves conducted trials. In many cases effects were not statistically significant.</p> <p>More, carefully conducted trials, that consider which subgroups benefit (or not) from particular styles of treatment delivery would be helpful to clinicians (e.g. group vs individual and parent-child vs child only) as would studies which considered treatment harms more carefully.</p> <p>Finally, this is an area where some observational studies of follow up in real world settings would provide important information about how symptoms develop and/or attenuate.</p>

			<p>decreases, one of which was statistically significant. In a meta-analysis, there was no evidence of an effect on average. Three studies provided longer-term data. The first of these observed a much smaller increase than the same study in the short term. Overall, the average effect was similar to that immediately after treatment, but was not statistically significant.</p> <p><b>ii) Externalising behaviour (e.g. aggression, 'acting out')</b>  Seven studies provided data on the Child Behaviour Checklist (CBCL) Externalising behaviour scale. A meta-analysis of standardised differences in means (due to different scoring systems being used for the scale) did not provide evidence of the beneficial effect on average (decrease of 0.14 standard deviations, 95% CI decrease of 0.44 to increase of 0.15).  However, the results were inconsistent (<math>I^2 = 62\%</math>; P value for heterogeneity 0.01), with one study observing a statistically significant increase and one a statistically significant decrease. Four studies provided longer term data. Again, the picture is of inconsistent findings that do not produce, on average, either a convincingly beneficial or harmful effect.</p> <p><b>C. Future offending behaviour</b>  <b>i) Of child when adolescent and/or adult.</b>  No study set out to examine this as an outcome.</p> <p><b>D. Parental skills and knowledge</b>  <b>i) Of child sexual abuse and its (possible) consequences</b>  No data were available on parental understanding of child sexual abuse.</p> <p><b>ii) Parental belief in their child's story</b>  Two studies used the PRIDS and PSQ scales respectively to measure parental belief of their children and support for them. A metaanalysis of standardised differences in means gave a statistically significant increase of 0.3 standard deviations (95% CI 0.03 to 0.57).</p> <p><b>iii) Accurate attributions for their child's behaviour or psychological problems</b></p>	
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			<p>One study provided data on four aspects of parental attributions (PAS scale), observing small, but statistically non-significant decreases in self-blame, child-blame, perpetrator blame and negative impact (see forest plot)</p> <p><b>iv) Parents Emotional Reactions</b> Two studies used the Parent Emotional Reaction Questionnaire and across these a decrease of 7 points (95% CI 3.9 - 10.1) was observed.</p> <p><b>v) Behaviour management skills</b> Three studies provided data on Parenting Practices Questionnaire scores in the short term, one of which looked also at long-term effects. A statistically significant increase of 4.4 across the two studies was observed immediately after treatment (95% CI 1.0 to 7.7) and a statistically significant increase in the single study of 11.9 after two years (95% CI 5.3 to 18.5).</p>	
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**Prevention of reoccurrence of child maltreatment and associated impairment**

**Critical appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Macmillan (2009)	Yes	Range of evidence from systematic reviews, good quality syntheses of reviews, and experimental studies.	Broad search, not a systematic review.	Not clear. Not a systematic review.	Studies identified by using database-specific terms used to identify the concepts of child maltreatment (child abuse, child neglect, child sexual abuse, exposure to intimate partner violence, foster care, shaken baby syndrome, etc.). These were paired with the controlled vocabulary terms appropriate for prevention and intervention	Narrative synthesis of key findings. More details provided of studies showing positive effects with higher levels of evidence, or in areas where debate exists about the effectiveness of an intervention.	Narrative	Yes	Not analysed in this paper.

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Macmillan (2009)	Prevention of recurrence and adverse outcomes associated with maltreatment. ( <i>Interventions aimed at prevention of maltreatment before it occurs are also reviewed but not included here</i> ).	Prevention of recurrence of child physical, emotional or sexual abuse and reduction of adverse outcomes associated with maltreatment.	Trained clinicians	Not specified.	Parents and/or children or young people where a child has been maltreated, neglected and/or sexually abused. Individual and group settings.	Not specified, but would follow reported occurrence of child maltreatment and/or sexual abuse.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Macmillan (2009)	RCTs and systematic reviews	<p>Programmes to prevent re exposure to and adverse outcomes of child maltreatment:</p> <p><b>Reoccurrence/cessation of maltreatment</b> physical abuse, emotional abuse and/or neglect, exposure to intimate partner violence.</p> <p><b>Child outcomes</b> including post-traumatic stress symptoms, post-traumatic stress disorder, anxiety, depression,</p> <p><b>Child behavioural problems</b></p>	<p><b>Physical abuse and neglect</b></p> <p><b>Parent-training programmes</b>            * Some evidence to support the use of parent-training programmes to reduce the recurrence of physical abuse            * Some programmes (e.g., Parent Child Interaction Therapy (PCIT) and the Webster-Stratton Incredible Years Program) are effective in improving some outcomes associated with physically abusive parenting            * Parent-child interaction therapy (PCIT) has the strongest evidence base for reduced recurrence of child-protection services reports of physical abuse (but not neglect)</p> <p><b>Home visiting programmes</b>            * Insufficient evidence to conclude that standard multifaceted in-home programmes alone reduce recurrence of physical abuse and neglect            * One programme of intensive nurse home visitation was not effective in preventing recurrence of physical abuse or neglect</p> <p><b>Neglect-specific programmes</b>            * Insufficient evidence to conclude that neglect-specific interventions reduce recurrence of neglect            * Some evidence from small studies that resilient-peer training, imaginative play training, therapeutic day training, and multisystemic therapy improve child outcomes (systematic review of controlled studies)</p> <p><b>Sexual abuse</b>  <b>Therapeutic counselling for children and families</b>            * Evidence that cognitive-behavioural therapy can improve specific mental-health outcomes for sexually</p>	<p>A specific parent-training programme has shown benefits in preventing recurrence of physical abuse; no intervention has yet been shown to be effective in preventing recurrence of neglect.</p> <p>A few interventions for neglected children and mother-child therapy for families with intimate-partner violence show promise in improving behavioural outcomes.</p> <p>Cognitive-behavioural therapy for sexually abused children with symptoms of post-traumatic stress shows the best evidence for reduction in mental-health conditions.</p> <p>For maltreated children, foster care placement can lead to benefits compared with young people who remain at home or those who reunify from foster care; enhanced foster care shows benefits for children.</p> <p>Future research should ensure that interventions are assessed in controlled trials, using actual outcomes of maltreatment and associated health measures.</p>

			<p>abused children with post-traumatic stress symptoms, including post-traumatic stress disorder, anxiety, depression</p> <p>* Conflicting evidence for cognitive-behavioural therapy in reducing child behavioural problems</p> <p><b>Emotional abuse</b></p> <p><b><i>Therapeutic counselling for parents/ families</i></b></p> <p>* Limited evidence of the effectiveness of interventions specifically designed for parents or caregivers who emotionally abuse their children</p> <p>* Group-based cognitive-behavioural therapy might be effective with some parents</p> <p><b>Exposure to intimate-partner violence</b></p> <p><b><i>Programmes to prevent recurrence of intimate-partner violence</i></b></p> <p>* Evidence for preventing children's exposure to intimate partner violence by reducing male to female IPV is limited; one post-shelter advocacy intervention showed improvement in women's life quality and initial, but not sustained, reductions in intimate-partner violence</p> <p>* Restraining orders against abusive partners might prevent recurrent abuse (prospective cohort), but batterer treatment programme evaluations have mixed, and generally negative, results</p> <p><b><i>Psychological treatment for parents and children</i></b></p> <p>* Some evidence for mother-child therapy in families where children are exposed to intimate-partner violence in reducing children's internalising and externalising behaviour problems and symptoms</p>	
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### Critical Appraisal

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/ exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Barlow & Schrader-McMillan (2010)	Yes	Any study design.	Yes	Yes	<p>Treatment of parents or parents and children (0 – 18) where children have been subject to a chronic pattern of emotional abuse or emotional neglect that does not include other forms of maltreatment.</p> <p>The followings types of studies were excluded:</p> <p>universal primary prevention; treatment in situations where emotional abuse co-occurs with other forms of abuse or physical neglect; interventions do not measure change in parent-child emotional interaction. Interventions that only measure change in risk factors, such severe mental illness (SMI) or depression could only be included if change in parenting/parent child interaction was assessed.</p>	Individual study results.	CI where data available.	Yes	Not specified

### Content

	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Barlow & Schrader-McMillan (2010)	Interventions designed to reduce/end child emotional abuse and emotional neglect that does not involve other forms of maltreatment.	Studies were organised according to the type of emotional abuse targeted: emotionally abusive parenting; parents of infants with faltering growth; missocialisation: parenting interventions with substance-abusing mothers.	Trained health professionals	Ranged from brief interventions to home visiting programmes over several years.	Varied	Identification of high risk or actual chronic emotional abuse and emotional neglect.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Barlow & Schrader-McMillan (2010)	<p>21 studies of 18 interventions. 12 were quantitative: 6 RCTs, 1 follow up of an RCT, 2 controlled trials; 3 pre-post designs. The remaining 9 studies were case studies.</p> <p>Studies were organised according to the type of emotional abuse targeted: emotionally abusive parenting; parents of infants with faltering growth; missocialisation: parenting interventions with substance-abusing mothers. 8 studies for parents which address emotionally abusive parenting (rejection, misattribution, parent-child role reversal and anger management) involved evaluations of cognitive-behavioural training (CBT), behavioural training and parent-infant psychotherapy.</p> <p>Two further case studies involved cognitive-behavioural training, mentalisation and family-based therapy.</p> <p>The 9 interventions with parents of infants with faltering growth evaluated CBT, behavioural training, parent infant psychotherapy and interaction guidance; lay home visitors, and a range of therapeutic options based on the diagnostic condition of the parents.</p>	<p>Impact of the intervention on emotionally abusive parenting using either parent- or child-report standardised measures or independent observations of the following: (i) parental attitudes and (ii) parental behaviour (iii) family functioning and/or (iv) the child's social, emotional, physical and developmental well-being and functioning. Diagnostic assessments by clinicians of emotional abuse, children's cognitive, motor, emotional and social development, and children's physical health were also included.</p>	<p><b>Interventions for emotionally abusing parents</b></p> <p>The findings from the 8 included studies evaluating CBT, psychotherapy, and behavioural approaches suggest that group-based CBT may be an effective means of intervening with this group of parents, although it cannot currently be recommended with parents experiencing symptoms of severe psychopathology. While one comparative study showed a psychotherapeutic intervention to be more effective than a CBT focused intervention, the outcomes measured in this study (i.e. parent and child representations) favoured the former.</p> <p>Behavioural case work involving the use of problem-solving techniques may also have a role to play with some parents, although further research is still needed.</p> <p><b>Interventions for parents of parents of babies with faltering growth</b></p> <p>Nine studies evaluated a range of interventions with parents of babies with faltering growth including interaction guidance, home visiting; parent-child psychotherapy, behavioural casework and multi-component interventions. The findings show that interaction guidance and parent-infant psychotherapy may be potentially effective means of working with this group of clients along with behavioural casework, but that further research is needed before these can be recommended.</p>	<p>The range of included studies reflects both the form and intensity of child emotional abuse and the absence of research.</p> <p>Emotional abuse is a complex issue resulting in part from learned behaviours, psychopathology and/or unmet emotional needs in the parents, and often compounded by factors in the families' immediate and wider social environment. As such, a 'one-approach-fits-all' is unlikely to lead to sustained change.</p> <p>The evidence base is weak, but suggests that some caregivers respond well to cognitive behavioural therapy. However, the characteristics that define these parents are not clear. There was no evidence to support the use of this intervention alone in the treatment of severely emotionally abusive parents. Some of the evidence suggests that a certain form of emotional abuse (for example, highly negative parent affect, which may be expressed as frightened and frightening behaviours in the parent) stemming from unresolved trauma and loss, is less amenable to CBT. There is some evidence that interaction guidance and psychotherapeutic approaches can generate change in parents with more severe psychopathology.</p>

	<p>The 3 studies of interventions for substance abusing mothers evaluated a relational psychotherapy group for mothers, and a residential treatment for substance abuse with a parenting component.</p>		<p><b>Interventions for substance-abusing parents</b>  Only 3 studies (one of which was a 6-month follow-up) evaluated interventions for substance abusing mothers, including a relational psychotherapy group, and a residential treatment for substance abusing adults with a parenting component. The findings show that initial gains by the relationship based psychotherapy group were not sustained at 6-months and outcomes were stronger for the control group. Few benefits were reported from residential intervention.</p>	<p>Further research is urgently needed to evaluate the benefits of both psychotherapeutic and cognitive behavioural interventions, including those which take the form of family therapy, with parents at the more severe end of the spectrum, with fathers, and with older children. There is also a need to gain further understanding about which forms of emotional abuse respond best to different treatments.</p>
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**Children of drug-dependent mothers**

**Critical appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Niccols (2012)	Yes	RCTs, quasi experimental studies, cohort studies. Included research that was part of wider studies.	Yes	Yes	Studies of treatment with at least one measure of one specific substance use treatment (e.g., individual or group therapy, methadone) and at least one parenting or child (< 16 years) treatment service (e.g., prenatal care, child care, parenting classes); 5) there was quantitative data on parenting or other outcomes as part of the larger study (length of stay, treatment completion, maternal substance use, maternal well-being, or child well-being).	Meta-analysis	CIs	Yes	Yes

**Content**

Author (Year)	Intervention(s) reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Niccols (2012)	Integrated substance abuse treatment programs that provide comprehensive services that address substance abuse as well as maternal and child wellbeing through prenatal services, parenting programs, child care, and/or other child-centered services in a centralized setting.	To end intergenerational cycle of addiction, dysfunctional parenting, and poor outcomes for children.	Trained professionals in residential or outpatient settings.	3 – 6 months for outpatient programmes. Integrated residential programs or "therapeutic communities" offer long-term (15-18 months) treatment services to women and their children.	Women who were pregnant or parenting with substance abuse problems at baseline;  Outpatient and residential settings.	Not specified.

## Results

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
Niccols (2012)	24 cohort studies, 3 quasi-experimental studies, and 4 randomized trials.	Maternal mental health outcomes, e.g. depression; parenting stress; caregiver behaviour; reflective functioning; representations of parenting.	<p>In the three randomized trials comparing integrated programs to addiction treatment-as-usual (<math>N = 419</math>), most improvements in parenting skills favored integrated programs and most effect sizes indicated that this advantage was small, <math>d_s = -0.02</math> to <math>0.94</math>.</p> <p>Results for child protection services involvement did not differ by group.</p> <p>In the three studies that examined factors associated with treatment effects, parenting improvements were associated with attachment-based parenting interventions, children residing in the treatment facility, and improvements in maternal mental health.</p> <p>Only two cohort studies and one randomized trial specifically examined factors associated with parenting outcomes.</p> <p>One indicated that reduction in depressive symptoms was significantly correlated with improvements in parenting competence, isolation, attachment, and role restriction.</p> <p>A second study found that when children resided in the treatment facility, mothers were five times more likely to have custody of their children at the end of treatment.</p> <p>An RCT of an attachment based parenting programme found that mothers in an attachment-based parenting intervention had improved scores for caregiving behavior and reflective functioning and a trend for more improved sensitivity than control group in parent education, but this advantage was typically small. At 6-week follow-up, there were no significant group differences in improvements in scores.</p>	<p>The limited available evidence supports integrated programs, as findings suggest that they are associated with improvements in parenting skills. The findings suggest that the risks to parenting could be minimized with intervention, which could have long-term impact. For example, integrated programs may improve parenting, which has been shown to reduce the risk of child maltreatment.</p> <p>Even though the advantage of integrated programs over addiction treatment-as-usual may be small, it could have a potentially large impact on the associated financial and human burden in this vulnerable population (e.g., it may reduce the need for foster care placement, child treatment, psychiatric admissions, crime, etc.).</p>

## Domestic violence interventions and treatment

**Note:** Because this is a very large and complex report, it has been split into the following sections:

- (i) interventions with victim-survivors of DV;
- (ii) Perpetrator treatment
- (iii) Interventions with children with and without a non-offending parent who have witnessed DV

### Critical Appraisal

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
British Columbia Centre of Excellence for Women's Health (2013)	Yes	Range of study designs: systematic review; randomised controlled trials (RCT); a case-control study; interrupted time series; cohort study; cross sectional study; observational study; or qualitative studies not included in a systematic review. Included grey literature.	Yes	Yes	Studies that evaluate an intervention/ approach to identify, prevent, reduce or respond to domestic violence between adults and young people who are, or have been, intimate partners, in health-care, social care and specialized domestic violence service settings.  Studies typically excluded that did not report on outcomes, or on selected outcomes.	Individual study results	CIs where applicable; otherwise p values or narrative accounts.	Yes.	IPV is a serious public health concern, with high incidence rates and significant costs to the healthcare system and the economy. However, further research is needed that provides more rigorous evidence on cost-benefits.

**Content: (i) Interventions for victim survivors of domestic violence**

Author (Year)	Intervention(s) reviewed <sup>147</sup>	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
British Columbia Centre of Excellence for Women's Health (2013)	Victims of DV: Advocacy interventions, skill-building interventions, counselling and brief interventions, and therapy interventions for victims of domestic violence.	Improve social, emotional outcomes for victims of domestic violence; prevent re-victimisation.	Trained practitioners/therapists.	Varied greatly, from brief interventions (counselling, forms of advocacy) to longer term therapies lasting between one and two years.	Victim survivors of domestic violence.  Range of settings including: hospital, community, shelters and home settings.	Not specified.

<sup>147</sup> The review also includes forms of violence that are outside the scope of this study.

**Results: (i) Interventions for victim survivors of domestic violence**

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
<p>British Columbia Centre of Excellence for Women's Health (2013)</p>	<p>33 included studies on interventions with victims.</p> <p>Interventions focused on:</p> <ul style="list-style-type: none"> <li>• Advocacy services improve women's access to community resources and access to entitlements</li> <li>• Skill building (teaching, training, experiential or group learning)</li> <li>• Counselling</li> <li>• Intensive therapy</li> </ul>	<p>The paper as a whole measures outcomes pertaining to each of the three key populations: (i) victim survivors of domestic abuse (ii) perpetrators (iii) children exposed to domestic abuse.</p> <p>This section focuses on : Indicators of mental and social functioning including PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, re-occurrence of violence, motivational level and/or readiness to change; birth outcomes for pregnant women.</p>	<p>Moderate evidence that advocacy services may reduce rates of IPV, improve safety, decrease depression, reduce various stressors, and improve parenting stress and children's well-being. While the majority of studies received a moderate quality rating, all studies on advocacy reported some improvements for victims, suggesting that this may be a promising approach for responding to DV.</p> <p>Moderate evidence that skill building on a range of topics with victims of partner violence has positive effects on victims' coping, well-being, decision-making abilities, safety and reduction of coercive and violent behaviour.</p> <p>Moderate evidence that counselling interventions may improve: PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, re-occurrence of violence, birth outcomes for pregnant women, motivational level and/or readiness to change. While most interventions reported improvements on the various outcomes measured, some reported only modest improvements or improvements on some but not all measures.</p> <p>Moderate evidence that more intensive therapy interventions such as group therapy may be effective for improving various PTSD symptoms, depression, trauma symptoms, psychological and social outcomes, parenting/ family-related outcomes and in some cases may reduce likelihood of future IPV or re-abuse</p>	<p>For victims, there was moderate evidence for advocacy and various approaches to skill development, counselling and therapeutic approaches. However, many studies reported high rates of attrition, and lacked follow-up beyond programme completion.</p>

(iv) Interventions aimed at changing perpetrator behaviour

Content:

Author (Year)	Intervention(s) reviewed <sup>148</sup>	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
British Columbia Centre of Excellence for Women's Health (2013)	<p>Perpetrators of DV: Group and individual therapies of varying duration, primarily grounded in CBT or Duluth models.</p> <p>Short duration group approaches (16 weeks or less) included: family of origin group therapy, a solution and goal focused group treatment programme, CBT, unstructured supportive group therapy, group counselling, and group sessions based on the Duluth model.</p> <p>Long duration approaches (over 16 weeks) included: CBT programs, psycho-educational components, abuser schema therapy, Duluth-based group therapy, and stages of change MI approach.</p> <p>Couples therapy, with and without adjunctive substance abuse components.</p>	<p><b>Perpetrators of DV:</b></p> <p>Aggressive feelings towards partner, attitudes, understandings of violence and accountability, short term help seeking.</p> <p><b>Couples: DV cessation</b></p>	Trained practitioners/therapists.	<p>Short duration group approaches (16 weeks or less)</p> <p>Long duration approaches (over 16 weeks)</p>	<p>(i) Perpetrators of domestic violence – male and female, although majority of studies involved male perpetrators only. Studies varied in whether participants were court mandated, non-mandated, or both.</p> <p>Very few studies examined the impact of interventions or approaches for diverse sub-populations of men or women (e.g. same sex couples), and no culturally specific programs were identified.</p> <p>(i) Couples affected by DV perpetration by one or both partners</p> <p>Very wide range of settings including but not restricted to: hospital, community, shelters and home settings in interventions for victim/children's/couples; court and community settings for perpetrators.</p>	Not specified.

<sup>148</sup> The review also includes forms of abuse e.g. elder abuse, that are outside the scope of this study.

## Interventions aimed at changing perpetrator behaviour

### Results:

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
British Columbia Centre of Excellence for Women's Health (2013)	<p><b>Work with perpetrators</b> (primarily male): Short duration group approaches (16 weeks or less) involving family of origin group therapy, a solution and goal focused group treatment programme, CBT, unstructured supportive group therapy, group counselling, and group sessions based on the Duluth model.</p> <p>Short duration group approaches (16 weeks or less) involving family of origin group therapy, a solution and goal focused group treatment programme, CBT, unstructured supportive group therapy, group counselling, and group sessions based on the Duluth model.</p> <p>Couples interventions: Behavioural couples therapy with or without substance use treatment; communication skills</p>	<p>The paper as a whole measures outcomes pertaining to each of the three key populations: (i) victim survivors of domestic abuse (ii) perpetrators (iii) children exposed to domestic abuse.</p> <p>This section focuses on: Attitudes and beliefs about violence, motivation to change, communication skills, conflict management.</p> <p>Violence perpetration.</p>	<p><b>Work with perpetrators:</b> Short duration group approaches: there is moderate evidence that short duration group interventions improve attitudinal, psychological and interpersonal outcomes among abusers. Two studies examining a group treatment programme for female batterers, found improvements on some, but not all psychological measures. However, is inconsistent evidence that these interventions reduce recidivism/abuse outcomes.</p> <p>Long duration approaches: Evidence of effectiveness was inconsistent with some studies reporting a reduction in recidivism/abuse outcomes, some reporting only temporary reductions or improvements in select measures of violence/aggression (e.g. physical but not psychological aggression), and some studies demonstrating no impact on recidivism. The evidence of effectiveness for long duration group interventions on attitudinal, psychological and interpersonal outcomes is also inconsistent. Evidence of effectiveness was inconsistent, with most studies demonstrating improvements (on measures such as: communication, motivation to change, attitudes towards violence, conflict management skills, etc.), but some studies revealing</p> <p><b>Couples interventions:</b> There is moderate evidence from four studies that behavioural couples therapy (BCT) included within substance use treatment is associated with improved abuse outcomes, and in some studies with improved substance use measures.</p>	<p>Overall the evidence of effectiveness of batterer intervention programmes (BIPs) is inconclusive. There is stronger evidence for changes in beliefs and attitudes associated with DV than on recidivism. In general, effect on recidivism was small or non-significant,</p> <p>Most included studies also have methodological limitations including: concerns over evaluation of attrition and outcome measures, potential bias in sample selection and in synthesis of qualitative data. There is a lack of conclusive data on the effectiveness of specific approaches (although motivational interviewing appears to be a promising approach.</p> <p><b>Couples interventions:</b> In general, studies that combined behavioural couple's therapy within substance abuse treatment reported improvements in</p>

	<p>training, psycho-educational group sessions for parenting couples, and MI principles during assessment feedback.</p>		<p>Weak evidence from three studies that couples interventions (which do not include treatment for substance users) are associated with a reduction in aggression outcomes or improvements in relationship skills, satisfaction and conflict.</p>	<p>partner violence/ aggression, although findings may not be meaningful for ethnically diverse couples.</p> <p>Given the lack of interventions for non-substance using couples, and diversity of approaches, samples used and outcomes measured in the available studies, it is difficult to form overall conclusions on the effectiveness of couples-based approaches.</p>
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iii) Interventions with children who have been exposed to DV

**Content**

Author (Year)	Intervention(s) reviewed <sup>149</sup>	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
British Columbia Centre of Excellence for Women's Health (2013)	Single or multicomponent interventions for children who had witnessed domestic violence.	Improved child emotional and behavioural functioning.	Not specified, but	Varied	Children who had witnessed DV with and without their mothers.	Not specified.

**Results**

Author (Year)	Included studies	Outcomes measured	Results	Author's conclusions
British Columbia Centre of Excellence for Women's Health (2013)	<p>1 systematic review (25 articles) studies of interventions for children who have witnessed DV.<sup>150</sup></p> <p>Interventions were: single or multi-component: therapy or psycho-education focused; Aimed at children, or mothers and children; and recognizing the mix of aspects such as advocacy, therapy and parenting.</p>	<p>The paper as a whole measures outcomes pertaining to each of the three key populations: (i) victim survivors of domestic abuse (ii) perpetrators (iii) children exposed to domestic abuse.</p> <p>This section focuses on: Children's behaviour and emotions, knowledge about violence.</p> <p>Reductions in mothers' stress and ability to manage children</p>	<p>Moderate to strong evidence that single component therapeutic interventions aimed at both mother and child are effective in improving child behaviour, mother-child attachment and stress and trauma-related symptoms in mothers and children. Intervention approaches included: mother-child psychotherapy, shelter-based parenting intervention combined with play sessions for children, parent-child interaction therapy (including mother-child play, teaching of praise and discipline techniques), and an experiential, activity based and interactive therapy intervention.</p> <p>Inconsistent evidence that single-component psycho-educational interventions aimed at mothers and children are effective in building coping skills, increasing knowledge of DV and improving children's behaviour and mothers' parenting skills. In some studies improvements were not sustained at follow-up, while other studies had significant methodological weaknesses limiting the formation of strong evidence of impact. These include: mother-child psychotherapy, shelter-based parenting intervention combined with play sessions for children, parent-child interaction therapy (including mother-child play, teaching of praise and discipline techniques), and an experiential, activity based and interactive therapy.</p>	<p>There is moderate evidence of effectiveness of multi component interventions focused on therapy and parenting aimed at diverse populations of mothers and children. These interventions showed moderate improvement in children's behaviour and emotions, knowledge about violence and reductions in mothers' stress and ability to manage children. All studies reported improvements for both children and mothers, and several of the studies were identified as rigorous. However, the</p>

<sup>149</sup> The review also includes subjects (e.g. elder abuse) that are outside the scope of this study.

<sup>150</sup> Rizo, C et al (2011) A review of family interventions for intimate partner violence with a child focus or child component. *Aggression and Violent Behaviour*, 16 (2011), 144-166.

			<p>Weak evidence regarding child-focused single component therapeutic interventions. Interventions varied widely, including: play therapy, expressive writing therapy, and equine assisted psychotherapy. Play therapy and equine therapy both demonstrated some improvements with diverse groups of children in behaviour, aggression and self-esteem, but there were only 3 studies in this area and these interventions are not comparable.</p> <p>Moderate evidence that single-component psycho-educational interventions (addressing skills such as: stress and conflict management, coping and relationship skills, understandings of violence, etc.) are effective in improving children's coping skills, behaviour, emotional regulation, conflict resolution skills and knowledge about violence. Studies as a whole were moderate in quality (many lacked follow-up, included small sample sizes, etc.) limiting the formation of a strong evidence of impact.</p> <p>Moderate evidence that multi component interventions with a focus on advocacy are effective in reducing the trauma symptoms and stress in both children and families, and in improving child behaviours such as aggression. Interventions included: community-based service planning, nurse case management, and non-parental child care for disadvantaged families. These studies were also of moderate quality.</p> <p>Moderate evidence of effectiveness of multi component interventions including both therapy and advocacy among diverse populations of women and children, some with co-occurring issues of substance use and mental health issues. These interventions increased knowledge and awareness about violence and safety planning, improved self-esteem and self-competence and improved interpersonal relationships. All studies reported improvements for children (with some noting variations between different age groups of children), but were moderate in quality.</p>	<p>majority of studies had significant methodological weaknesses, which limit the formation of strong conclusions regarding effectiveness.</p>
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## Neglect

### Critical Appraisal

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Allin (2005)	Yes	Observational and experimental studies with a comparison group	Yes	Yes	The review used the definition of neglect as 'an act of omission rather than commission that occurs when children's basic needs are not adequately met'. Studies with overlapping samples of children who had experienced neglect and abuse were also included. Studies of children who failed to thrive were not included unless it was due to neglect. The studies included in the evaluation involved children or families in which the child had experienced neglect and/or abuse. The participants included pre-school children	Narrative	Narrative	Yes	Not assessed

### Content

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Allin (2005)	Studies that assessed the occurrence of neglect or any associated physical, emotional or cognitive outcome measure were eligible for inclusion.	Improve impact of neglect on children's emotional, social or cognitive outcomes; some interventions also aimed to improve parent child interaction.	Not specified	Varied from 8 sessions of therapy to daily therapeutic day centre treatment daily for nine months.	Therapeutic nursery, Sure Start centres, residential care, school, home and clinic settings.	Not specified. Child age ranged from preschool through to adolescence.

**Results**

Author (Year)	Included studies	Relevant Outcomes measured	Results	Author's conclusions
Allin (2005)	Five studies: Four RCTs and one prospective cohort study.	Parental behaviours associated with child neglect, recidivism, substantiated child neglect, family reunification and other measures related to the functioning of the parent or child. The included studies assessed a variety of outcomes; most studies included assessments made by observation (details of the outcomes and methods used were reported for studies included in the evaluation).	<p><b>School based resilient peer intervention:</b> one RCT (46 children) reported that a resilient peer intervention was associated with significantly more positive play and less solitary play at 2 weeks and improved social interaction and fewer internalising and externalising behaviour problems at 2 months than a no treatment control intervention.</p> <p><b>Imaginative play training:</b> One RCT (34 children) reported that imaginative play training was associated with increased imagination, cooperation and interaction with peers, and less aggressive play compared with play sessions.</p> <p>1RCT (41 children) reported that play therapy plus milieu therapy was associated with only one positive outcome out of thirteen measured outcomes compared with milieu therapy alone; the positive outcome was less isolated play post-treatment, but this benefit was not maintained at 10 weeks.</p> <p><b>Centre based day therapeutic programme:</b> A prospective cohort study reported that a centre-based day therapeutic programme was associated with significantly greater perceived cognitive competence, peer and maternal acceptance and higher developmental level post-treatment, but not physical competence, compared with no treatment.</p> <p><b>Multisystemic therapy</b> One RCT (33 families) reported that individualised multisystemic therapy appeared to reduce negative parent-child interactions compared with parent training, but parent training reduced social problems.</p>	There was limited evidence from a small number of studies and further research is required. There was some support for resilient peer treatment and imaginative play training, multisystemic therapy and a specific therapeutic day treatment programme.

**Interventions with families in complex child protection cases.**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
Thorburn (2009)	Yes	Range of study designs and other narrative reports	Not stated	No	Not specified	Narrative	Narrative	Yes	Not assessed

**Content**

Author (Year)	Intervention(s) reviewed <sup>151</sup>	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
Thorburn (2009)	Strategies for identification and assessment of families in complex child protection cases.  Interventions designed to ensure child protection and improve child wellbeing.	Prevention of further maltreatment or significant impairment to the child's development.	Varies	Varies	Varies	Not specified.

**Results**

Author (Year)	Included studies	Relevant Outcomes measured	Results	Author's conclusions
Thornton (2006)	Non-systematic review of the literature on a identification, assessment, engagement and interventions. Broad range of studies.	<p>Evidence of effective interventions engagement of families</p> <p>Evidence on what improves child protection and well-being</p>	<p>A combination of services and interventions will usually be needed in cases of complex, hard to reach families.</p> <p>Each case has to be researched, both by the careful collection and analysis of what is known, and matching that against the knowledge base of what may be effective in the particular child's and family's circumstances.</p> <p>Apart from the consistent conclusion about the centrality of the professional relationship, no one service approach or method has yet been robustly evaluated as effective with complex families where there is evidence of maltreatment, or where maltreatment is likely unless effective services are provided.</p> <p>Other approaches and interventions that have not yet been rigorously evaluated, but are positively rated by children and parents, should not be automatically viewed as less effective than 'model' programmes, but their impact on child well-being should be carefully evaluated using a range of appropriate methodologies.</p> <p>To achieve this, practitioners and managers in specialist services should consider how best to engage with children and families who are hard to reach and hard to change.</p>	<p>Whilst there is a growing knowledge base about promising approaches to supporting families and changing harmful parenting practices in complex child protection cases, there is no clear message from research that any specific service approaches or methods will be effective with abusing families.</p> <p>Policy-makers should identify broadly how many of what sorts of potentially maltreating families exist in their area. The knowledge is there to help them to do this, in that much is now known about the impact of a range of parenting behaviours, histories, contexts and relationships on children's lives. This involves attention at a community as well as an individual case level.</p> <p>This should bring together individual risk assessment, analysis of needs and risk of maltreatment, which can then be matched with an audit of how the approaches and services currently available fit with what is known about best professional practice across the disciplines. We are still some way away from having a 'menu' of methods known to be effective, particularly with complex families who are hard to reach and hard to change. It is therefore essential that practice developments are reported and shared in order to promote the development of knowledgeable and creative options.</p>

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Table 7: Targeted Youth Services

**Critical Appraisal**

Author (Year)	Review addresses a clearly focused question	Type of studies included	Comprehensive search undertaken	Quality of included studies assessed	Inclusion/exclusion criteria	Results presented	Precision of results	Applicable to UK settings	Do benefits outweigh harms and costs
O'Mara (2010)	Yes	Any study type.	Yes. Rapid review.	Yes	<p>Studies of targeted interventions and services focused on support to vulnerable young people, at risk of or with identified problems such as substance abuse, youth offending, school exclusion, homelessness, teenage pregnancy, learning, social, and emotional difficulties and are aged 11-19.</p> <p>Exclusion criteria not specified, as a broad range of study types and outcomes is included.</p>	Individual study results	Narrative and percentages	Yes	Despite a thorough separate search, author concludes that there is a lack of data concerning the costs of TYS interventions and the cost-effectiveness of these programmes.

**Content**

Author (Year)	Intervention reviewed	Intervention aim	Intervention delivery	Intervention frequency and duration	Intervention target and setting	Timing
O'Mara (2010)	30 studies that focused on effectiveness of YTS 10 of these studies included information on cost effectiveness.	<p><i>Increase participant wellbeing:</i></p> <ul style="list-style-type: none"> <li>• Increased confidence</li> <li>• Stronger family relationships</li> <li>• Increased emotional wellbeing</li> </ul> <p><i>Changed behaviours</i></p> <ul style="list-style-type: none"> <li>• Lessening antisocial and criminal behaviour</li> <li>• Reduced truancy and school exclusion</li> </ul> <p><i>Social status</i></p> <ul style="list-style-type: none"> <li>• Increased grades and educational achievement</li> <li>• Employment and skills</li> </ul> <p><i>Reduction of Teenage pregnancy</i></p>	Not specified in detail.	Not specified.	<p>Targeted population is defined slightly differently across studies. In general there are two core groups:</p> <p>11 – 19 years year olds who are at risk of or have been identified as having problems such as substance misuse, youth offending, teenage pregnancy, homelessness, or difficulties in social or emotional functioning or with learning.</p> <p>Parents and careers of adolescents with support needs.</p> <p>Programmes take part in community, school and home based settings.</p>	Not stated

## Results

Author (Year)	Included studies	Relevant Outcomes measured	Results	Author's conclusions
O'Mara (2010)	A very wide range of studies including: 7 reviews; 6 surveys, 4 RCTs, 4 controlled trials, and qualitative/mixed methods work. Several studies involved mixed methods.	<p><i>Changed attitudes</i></p> <ul style="list-style-type: none"> <li>• Increased confidence</li> <li>• Stronger family relationships</li> <li>• Increased emotional wellbeing</li> </ul> <p><i>Changed behaviours</i></p> <ul style="list-style-type: none"> <li>• Lessening antisocial and criminal behaviour</li> <li>• Truancy and school exclusion</li> </ul> <p><i>Social status</i></p> <ul style="list-style-type: none"> <li>• Increased grades and educational achievement</li> <li>• Employment and skills</li> </ul> <p><i>Teenage pregnancy</i></p>	<p><i>Changed attitudes</i></p> <ul style="list-style-type: none"> <li>• <b>Increased confidence:</b> consistent and general increase reported for participants confidence</li> <li>• <b>Stronger family relationships:</b> while improvement of family relationships is not the primary objective of interventions each study reported gains in these areas.</li> <li>• <b>Increased emotional wellbeing:</b> reduction in depressive symptoms reported in two studies. This is attributed in one study to increased parental involvement. Systematic review level evidence found to support cognitive behaviour interventions across educational environments and gender.</li> </ul> <p><i>Changed behaviours</i></p> <ul style="list-style-type: none"> <li>• <b>Lessening antisocial and criminal behaviour</b> all studies reported drops in antisocial behaviour, but strongest evidence shows (review with meta-analysis) showed a 19% decrease in antisocial behaviour scores.</li> <li>• <b>Truancy and school exclusion:</b> Two studies (1 systematic review) reported reductions in school exclusion. Systematic review found evidence to support CBT to reduce school exclusion.</li> </ul> <p><i>Social status</i></p> <ul style="list-style-type: none"> <li>• <b>Increased grades and educational achievement (see also teenage pregnancy, below).</b> Two studies reporting on educational achievement were mixed. One (UK based) reported improved attitudes to learning but did not measure grades. The</li> </ul>	<p>TYS interventions can be effective in:</p> <ul style="list-style-type: none"> <li>○ reducing teenage pregnancies and promoting positive behaviours.</li> <li>○ reducing emotional and behavioural problems, including delinquency/offending, school exclusion and truancy.</li> <li>○ Increasing emotional wellbeing and confidence</li> <li>○ Increasing participation in education.</li> <li>○ Benefits can go beyond intended consequences e.g. on family relationships and improving parental engagement.</li> </ul> <ul style="list-style-type: none"> <li>• One-on-one youth work has been found to be effective.</li> <li>• Successful TYS involves systematic staff training and ongoing workforce support. This needs to be integrated into the design of the intervention.</li> <li>• Successful TYS interventions build and maintain strong relationships (a) between agencies, (b) with communities and (c) at the one-to-one level with young people.</li> <li>• Schools are the main site for the uptake and recruitment of young people into TYS interventions; agencies should work closely with schools especially to access hard to reach populations, e.g. excluded children.</li> <li>• Good information on vulnerable young people needs to be gathered, recorded and shared by schools in order to support integration and the referral process.</li> <li>• More consistent definitions of 'at risk' and 'vulnerable' are needed to ensure right match with services.</li> <li>• Young people's input and participation is essential for successful design</li> </ul>

			<p>second, US based, study found no effect on completion of high school in the</p> <ul style="list-style-type: none"> <li>• <b>Employment and skills</b> positive results reported in three UK and one US based studies for children’s engagement in education, employment and training.</li> </ul> <p><b>Teenage pregnancy</b></p> <ul style="list-style-type: none"> <li>• Limited evidence in UK settings. A UK based evaluation of 6 UK programmes found a reduction of 11% over a seven year period but strong variation in effectiveness between localities. Stronger evidence to support US based programmes that show that promotion of educational opportunity and relationship education is more effective at reducing pregnancy than sex education alone. “Participants may have encountered more risk oriented peers in the programme centres than in comparison centres”.</li> </ul>	<ul style="list-style-type: none"> <li>• Robust monitoring and evaluation of the costs and progress of TYS interventions should be prioritised</li> <li>• Further research is needed on barriers to engagement of young people</li> </ul>
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