



Submission to 'Protecting Victoria's Vulnerable Children Inquiry 2011'

With particular reference to term of reference 1.1.5, the introduction of a public health model

Contents

Summary of the submission's conclusions.....	2
Introduction.....	3
The UK programme on prevention of domestic and sexual violence and abuse (VVAPP)	3
Key elements in public health framework for responding to violence and abuse: protecting vulnerable children.....	4
Evidence summaries.....	7
Primary prevention.....	7
Supporting protective factors and resilience	7
Primary prevention - programmes in schools	9
Primary prevention –programmes outside school.....	10
Secondary Prevention – working with children who display sexually inappropriate behaviour	13

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Summary of the submission's conclusions

1. A 'Public Health Model' should be articulated and adopted to aid prevention of, and early intervention in, child abuse and neglect.
2. There are a number of very important points to be made about such a public health framework:
 - A public health model for protecting vulnerable children needs to be seen as an important part of, but inseparable from, a public health framework to tackle violence and abuse throughout civil society. Further:
 - Services for children and adolescents cannot be considered in isolation, a holistic society-wide approach is required. Services directed at the adult population are an important part of protecting children.
 - The model needs to cover the three different levels/types of prevention: primary prevention (preventing abuse and neglect *before* they occur); secondary prevention (early intervention targeted to groups and individuals who exhibit early signs of perpetrating abuse and neglect or being subject to it); and tertiary prevention (providing support and treatment to victims of child abuse and neglect, including amelioration of consequences and implementing measures to prevent repeat perpetration and repeat victimisation). This submission focuses particularly on primary prevention.
 - While past experience of abuse in childhood is not sufficient to explain or cause perpetration in adulthood, there is a link and therefore healing of historical abuse experienced as a child needs to be part of a public health model for protecting vulnerable children.
3. Primary prevention: There is need for
 - Society-wide awareness-raising and work to change attitudes towards violence and abuse.
 - A much wider provision of information on services throughout the community, for all age groups, across the life cycle.
 - Help lines for those concerned about their own behaviours, or for the behaviours of others.
 - Support services for all at-risk families around and following the birth of children.
 - Early education and school-based programs focussed on respectful relationships and anti-bullying behaviours in children, adolescents and young people. Positive mental health promotion programs can be integrated with these school-based programs.
4. Secondary and tertiary prevention: There is a need for:
 - Services for victims/survivors of abuse
 - Services for perpetrators of abuse
 - Services for perpetrators to be provided across the life course – for children, young people and adults.

Introduction

A starting point for detailed consideration of the answer to the questions outlined in TOR 1.1.5 can be found in work recently completed for the UK Department of Health's Victims of Violence and Abuse Prevention Programme. Drawing together results from specially commissioned research, the views of experts by experience, experts by profession and the published research literature, this work argued that sufficient is already known to delineate an appropriate public health framework, encompassing primary, secondary and tertiary prevention, to successfully tackle the important public health issue represented by sexual and domestic violence and abuse. It is important to acknowledge that while the remit of UK work was certainly not the same as that involved in the present inquiry, the evidence base, in terms of empirical research and professional expertise has considerable overlaps and the core principles of prevention and care, respect and privacy, and victim-centred services are applicable to contemporary Australian settings. There is good research evidence that a public health model is effective in relation to these difficult areas of community, public and private life, including in the area of child abuse and neglect as evidenced by a 'review of reviews', drawing on high quality systematic reviews of evidence. The experts involved in the Delphi consultations strongly endorsed the public health approach as the only way of eventually reducing the levels of child abuse and neglect in society. This submission presents selected findings and analysis from the work carried out for the UK programme on prevention of domestic and sexual violence and abuse to help identify elements of a suitable public health framework for protecting vulnerable children, and to integrate this with some other relevant programmes within Victoria.

The UK programme on prevention of domestic and sexual violence and abuse (VVAPP)

One piece of research commissioned for the UK programme was a three round Delphi consultation with UK 285 organisations/individuals drawn from experts in the field. This Delphi consultation was undertaken to identify where there is and is not consensus among experts about what is known and what works in the treatment and care of people affected by child sexual abuse, domestic violence and abuse, and rape and sexual assault. It enabled the identification of areas of agreement and disagreement about effective mental health service responses, and thereby contributed to the evidence base in this area. The full peer-reviewed research report of the consultation is now available from the Department of Health's website in the section on 'policy and guidance'¹. Over half² of the experts were experts in child abuse and neglect.

Findings from the Delphi consultation, put together with other contributions from research supported by the Department of Health and Home Office in the UK, as well as research published

¹ Itzin C, Tacket A, Barter-Godfrey S (2010) Domestic and Sexual Violence and Abuse: Findings from a Delphi expert consultation on Therapeutic and Treatment Interventions with Victims Survivors and Abusers, Children Adolescents and Adults. Melbourne, Deakin University. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123971

² 163 of the 285 individuals/organisations who took part in the Delphi consultation had expertise in child abuse and neglect.

since then, were drawn together in a book³. The book presents a social-ecological framework for understanding the issue of domestic and sexual violence and abuse. Its aim was to explore what is known about the public health challenge posed by domestic and sexual violence and abuse and its health and mental health effects. An important part of the work involved analysis of empirical research in child abuse and neglect, including research based on a wide range of research methodologies, including randomised controlled trials. Taking a life-course approach, the book explores what is known about appropriate treatment responses to those who have experienced violence and abuse, as well as those who perpetrate violence and abuse. Specially commissioned chapters within book examine key factors that are important in understanding how and why different groups experience heightened risks of violence and abuse. These chapters examined: gender and sexuality; race and culture; disability; and abuse by professionals.

The figure on page 5 summarises the public health prevention framework that emerged from the Delphi consultation plus reviews of research evidence. Its key components in terms of primary and secondary prevention are summarised on pages 4-6. Finally, more detailed evidence from research is presented on pages 7-13 and discussed alongside other Victorian-based work and initiatives. To keep this submission of manageable length, this is restricted mainly to primary prevention.

Key elements in public health framework for responding to violence and abuse: protecting vulnerable children

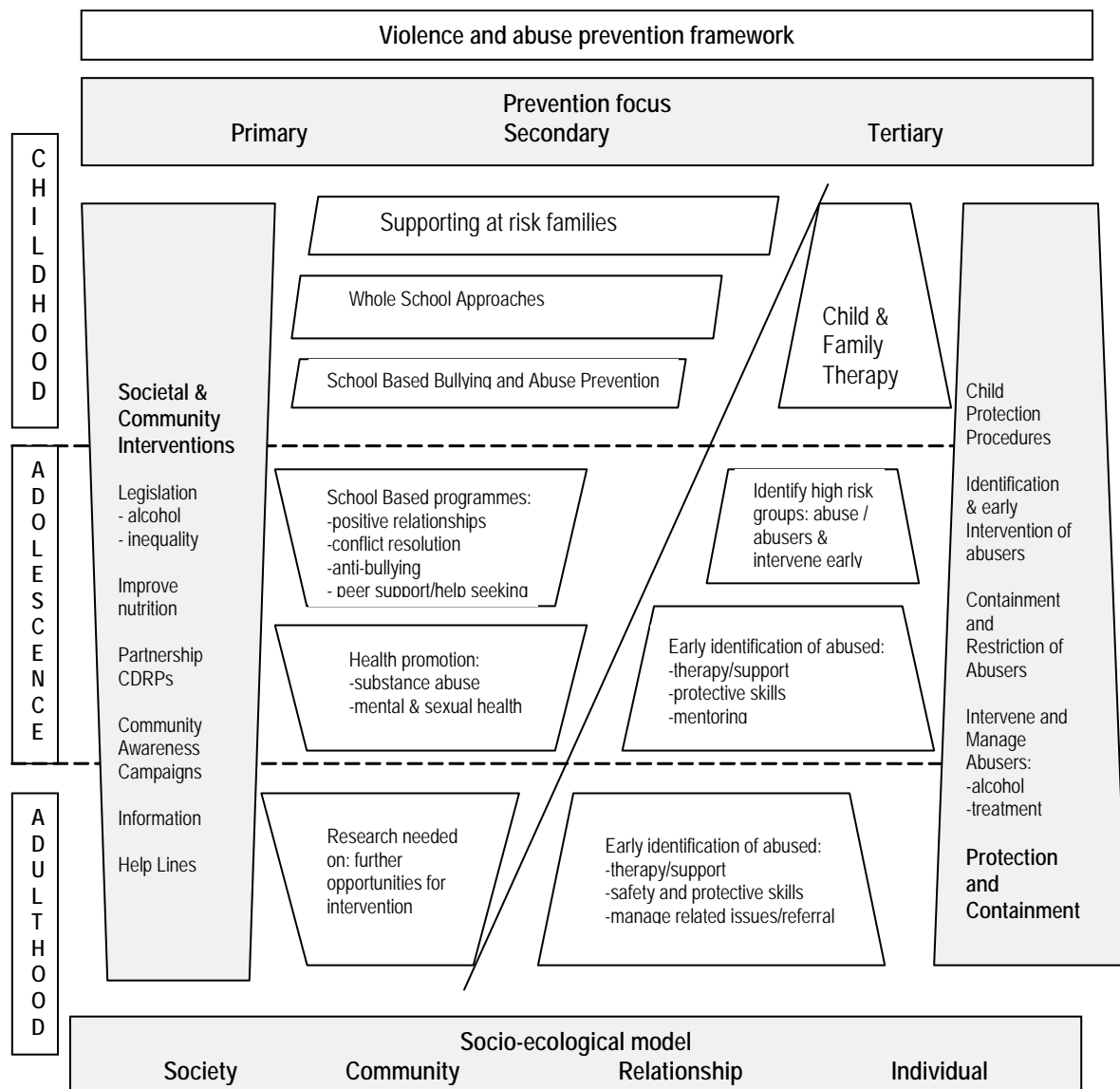
The Delphi experts overwhelmingly emphasised the importance of a public health approach to prevention, first and foremost aimed at changing societal attitudes to violence and abuse. The elements of the approach they identified are briefly outlined below, focussing on those elements of most relevance to protecting vulnerable children.

Diversity, inclusion, equal treatment and basic human rights principles were strongly suggested as fundamentally important, suggesting that a human rights/equalities framework was a required basis for policy and practice, with explicit attention to gender, sexuality, ethnicity, and disability within this. A second over-arching theme was the notion of the importance of a victim/survivor centred approach (associated with characteristics such as empowerment, and giving control and choice to victims/survivors); this was suggested, by some, to include choice for victims/survivors in terms of the gender, sexuality and age of the person they work with.

Sexual and domestic violence and abuse need to be made public health issues, with a public awareness campaign stressing personal responsibilities and rights; much more openness and acknowledgement of levels of sexual violence and abuse is needed. There needs to be an engagement with the media to ensure a balance between airing of the sensational or confrontational aspects of abuse (which attracts good audiences) with the important but softer informational and educational content that those who are quietly or secretly living with memories prior to disclosure need. Awareness and information sessions need to be provided in schools as part of the curriculum. Sexual and domestic violence and abuse need to be made priority issues for education services, with additional support for teachers who are supporting pupils who disclose.

³ Itzin C, Tacket A and Barter-Godfrey S Eds (2010) Domestic and Sexual Violence and Abuse: Tackling the Health and Mental Health Effects. London, Routledge, ISBN13: 978-0-415-55532-6.

A framework for responding to violence and abuse



Source: Itzin et al, 2010 page 175, whose diagram was adapted and updated from Nurse (2006)⁴

Note: in the figure CDRP stands for Crime and Disorder Reduction Partnerships – a UK interagency mechanism for geographically defined areas consisting of public and private agencies each with their part to play in reducing crime and disorder in the area.

The need for application of a basic public health model (of identifying risk factors and strengthening protective factors in the individual, the family, the community and society within various age bands) was emphasized. Prevention needs to be approached as any other major public health campaign, with appropriate components for primary, secondary and tertiary prevention.

The primary prevention required includes work in all sectors (schools, youth settings, workplaces) aimed at changing attitudes to all forms of violence and abuse. Large scale public awareness programmes aimed at changing attitudes to violence and abuse, to include understanding of what

⁴ Nurse, J. (2006) Preventing Violence and Abuse: Creating Safe and Respectful Lives, South East Regional Public Health Group Information Series 1, London: DH and HO.

consent means; need to be carried out at general population level and within all cultural/ethnic communities involving women in the community and community leaders. Throughout all sectors of society, organizations need to proactively 'model' non abusive and empowering behaviours. Workplace bullying and harassment policies have a role to play here.

The secondary prevention required includes better risk assessment and better targeting of those that are vulnerable to abuse or being abused⁵ including service provision, help lines, support work etc. and engaging adults in abuse prevention. There is a need for training and building skill capacity within a wide range of statutory and voluntary agency workers in order to begin to address the problem when it does present itself to services. Early identification and intervention with families (to be carried out in a range of different settings, e.g. GPs, mental health, maternity, A & E departments., social services, schools). Appropriate systems (information sharing and intervention protocols) need to be in place to ensure early intervention in any abuse by professionals of their clients. The UK guidelines for suspicion of child maltreatment in terms of emotional, behavioural, interpersonal and social functioning (NCCWCH 2009)⁶ can be of assistance in health settings.

The tertiary prevention required includes therapeutic support for victims/survivors, effective treatment and accountability for perpetrators. One very important aspect is to make it easier to report crimes and reassure victims about how they will be supported. Children and young people are most likely to be safe and keep safe if they understand their right to be safe, have been helped to develop the confidence to speak out if they feel danger, or do not like what is happening; have a secure base within family or substitute family; and there is at least one adult they can talk to. Therefore building children's self esteem and self worth and listening and taking them seriously should be at the core of all universal services and should be part of a strategy in school settings for equipping children to grow safely and healthily, with an understanding of healthy relationships and consent. This needs to be developed through adolescence into knowledge and understanding about safe dating. Education of learning disabled people about sexual activity and relationships is also required.

A major challenge is in achieving the necessary high level of integration and coordination at all levels in the implementation of a public health approach, given the multiple sectors and parts of the service system that are involved⁷.

Research has given us insight into a variety of different approaches that work in terms of providing for positive outcomes. The amount of evidence from well designed, well executed studies is still low in some cases (below what some sets of criteria regard as sufficient). To a great extent this reflects the limitations on available research funding – particularly for studies with the long follow-up periods necessary to assess long term impact of preventive programs. Further research is necessary to increase the amount and quality of evidence available, and to enable us to better understand how to tailor a package of services and responses to the needs of particular individuals. However, the evidence that does exist, including that from expert experience, does allow key elements in a public health framework for the protection of vulnerable children to be set out.

⁵ This would include targeted work to address groups at particularly high risk such as excluded families, see submission by Mitchell and Campbell included in submissions from the Alfred Felton Research Program, University of Melbourne.

⁶ NCCWCH National Collaborating Centre for Women's and Children's Health (2009) When to suspect child maltreatment, commissioned by the National Institute for Health and Clinical Excellence, London: Royal College of Obstetrics and Gynaecology Press.

⁷ For examples of some of these issues in terms of the interface between different parts of the service system and how these might be addressed, see the submission by Wesley Mission Victoria.

Evidence summaries

Primary prevention

The first aspect to emphasise is the importance of primary prevention, universal programmes aimed at whole populations – to tackle cultures of normalised violence and sexualisation of children, to give knowledge of rights to choice and control to children, and to empower them with the skills and confidence to assert their own wishes. Here programmes targeted at children and young people are considered, focusing first supporting protective factors and resilience, then on programmes in schools and finally on programmes outside schools.

Supporting protective factors and resilience

An understanding of protective and other factors which may moderate or increase risk (e.g. severity of violence, frequency and duration of exposure, and maternal coping strategies) is important for framing appropriate responses (Carlson 2000; Kolbo et al. 1996)⁸. The concept of resilience, understood, not as some form of innate toughness inherent only in a few individuals, but a human capacity that can be developed and strengthened in all people, through relationships, specifically through growth-fostering relationships (Hartling 2008)⁹ is useful in understanding the differential patterns of response that can be observed in situations of violence and abuse.

In the literature on coping strategies it is common to distinguish between two different types: avoidance and approach (Roth and Cohen 1986)¹⁰. Avoidance coping is seen as a passive strategy, it involves denial, behavioural disengagement, distraction, and sometimes withdrawal or hiding, whereas approach or problem-focused coping is seen as active coping, involving planning, positive reframing. A subset of this involves seeking support (emotional or instrumental). A further type of coping distinguished is venting coping, involving venting and self-blame. Avoidance coping is often labelled as maladaptive, and while this may be an accurate description in the long term, in the short term, for a young child, this may be the best, or even only, available strategy. The advisability of labelling particular types of coping as maladaptive is to be questioned in any case, as it runs the risk undermining victims' acts of resistance in the face of abuse, and mitigates against the facilitation and support of strengths-based approaches to coping.

Some abused children exhibit resilience despite the severe adversity in their lives (Cicchetti and Rogosch 1997; McGloin and Widom 2001)¹¹. Unfortunately not enough is known about how such resilience can be facilitated and supported. Research into protective and supportive factors is limited, but has already identified three general categories of important protective factors:

⁸ Carlson, B.E. (2000) 'Children exposed to intimate partner violence: research findings and implications for intervention', *Trauma, Violence and Abuse*, 1(4): 321-342.

Kolbo, J.R., Blakely, E.H. and Engleman, D. (1996) 'Children who witness domestic violence: A review of empirical literature', *Journal of Interpersonal Violence*, 11(2): 281-93.

⁹ Hartling, L.M. (2008) 'Strengthening resilience in a risky world: it's all about relationships', *Women and Therapy*, 31(2-4): 51-70.

¹⁰ Roth, S. and Cohen, L.J. (1986) 'Approach, avoidance and coping with stress', *American Psychologist*, 41(7): 813-19.

¹¹ Cicchetti, D. and Rogosch, F.A. (1997) 'The role of self-organization in the promotion of resilience in maltreated children', *Development and Psychopathology*, 9: 797-815.

McGloin J.M. and Widom, C.S. (2001) 'Resilience among abused and neglected children grown up', *Development and Psychopathology*, 13: 1021-38.

individual; family; and external support systems (Hartman et al. 2009)¹². Schulz et al. (2009)¹³ found three potential protective factors, social competence, adaptive functioning skills and peer relationships, were positively related to outcomes for children investigated for maltreatment. Research is also beginning to illustrate the range of social and cultural factors that can play a protective role. For example Kim (2008)¹⁴ demonstrates that child religiosity may largely contribute to stress coping process among children from low-income families; his study also indicates that the protective roles of religiosity varied by risk status and gender. One problem however is that the scope of operation of such protective factors, particularly within the individual and the family may be compromised by the abuse, or its consequences.

Exposure to violence and abuse in childhood is of particular importance given its scope for enhancing the likelihood of negative effects in later stages of life. This occurs not only through what the child learns about acceptable behaviour and responses to different situations, but is also linked to neurobiological effects mediated by genetic and environmental factors as discussed earlier. While attention is often paid to the vicious cycle of abuse, and to intergenerational effects, it is important to emphasise that most of those who are victims of abuse in their own childhood do not go on to abuse others (Langstrom, 2001)¹⁵.

Behavioural responses such as hyper-vigilance or extreme passivity, can be useful, even life-saving coping responses to an abusive home; they are less useful when they are present in a non-threatening environment, and all too easily are labelled as pathology and responded to in ways which do not assist in the development of different behavioural responses for the non-abusive environment, but rather reinforce the problematic behaviour (Jenny et al. 2008)¹⁶. As Jenny et al. (2008) emphasise, non-abusive caregivers for a child with difficult behaviours need to understand the roots of these behaviours and to learn ways of responding to these.

Several protective factors have been identified, protecting against initiation of abuse and its long term effects, including a supportive and stable family environment, school attainment and success, individual assertiveness, age-appropriate sex education and positive role models, both within the peer-group and as responsible adults. Surveys with young people commonly find violence-supportive attitudes, especially that hitting women and coercing sex is acceptable, and societal influences and attitudes may lead towards or away from resilience, and community education is implicated in developing resilience in young people (DH 2005b)¹⁷. Programmes that seek to build resilience against victimization and perpetratorhood in adolescent dating, including education, knowledge and attitude elements, have been identified as a 'promising approach' reducing rates of perpetration for both boys and girls compared to controls (Whitaker et al. 2006: 160)¹⁸. There is also some emerging evidence that adolescent boys' and girls' resiliency is built by different combinations

¹² Hartman, J.L., Turner, M.G., Daigle, L.E., Exum, M.L. and Cukken, F.T. (2009) 'Exploring the gender differences in protective factors: implications for understanding resiliency', *International Journal of Offender Therapy and Comparative Criminology*, 53(3): 249-77.

¹³ Schultz, D., Tharp-Taylor, S. Haviland, A. and Jaycox, L. (2009) 'The relationship between protective factors and outcomes for children investigated for maltreatment', *Child Abuse and Neglect*, 33(10): 684-98.

¹⁴ Kim, J. (2008) 'The protective effects of religiosity on maladjustment among maltreated and nonmaltreated children', *Child Abuse and Neglect*, 32(7): 711-20.

¹⁵ Langstrom, N. (2001) *Young sex offenders: a research overview*, Stockholm, Sweden: The Board of Health and Welfare.

¹⁶ Jenny, C., Christian, C. W., Hibbard, R. A., Kellogg, N. D., Spivack, B. S., Stirling, J., Albers, L. M. H., Hermon, D. A. and Mason, P. W. (2008) 'Understanding the behavioural and emotional consequences of child abuse', *Pediatrics* 122(3): 667-73.

¹⁷ DH (2005b) *Responding to Domestic Abuse: A Handbook for Health Professionals*, London: DH.

¹⁸ Whitaker, D. J., Le, B., Hanson, R. K., Baker, C. K., McMahon, P. M., Ryan, G., Klein, A. and Rice, D. D. (2008). 'Risk factors for the perpetration of child sexual abuse: A review and meta-analysis', *Child Abuse and Neglect* 32(5): 529-48.

of factors, although both genders seem to be more resilient when more protective factors are accumulated, including home and school environments and measures of self-worth (Hartman et al. 2009)¹⁹. For young people in foster care, resiliency also appears to be built by an accumulation of positive factors, including internal factors such as perceived self-competencies and external factors such as social support and engagement with social activities (Hass and Graydon 2009)²⁰.

Our ongoing research²¹, funded by the ARC, is exploring in detail the conditions and characteristics of 'resilience' in children and young people, and the types of interventions (educational, health, employment related, leisure) that work to improve individual and familial opportunities. The project has two related dimensions in its investigation of resilience in students: as produced through the interaction between family, schools and community; and the conditions, relationships, strategies, and interagency collaborations that support its production in specific contexts.

Primary prevention - programmes in schools

A variety of programmes cover school based social development training and student education and skill development regarding abuse awareness and prevention, anti-bullying, 'healthy' relationships (family and friends), and seeking help. Topping and Barron (2009)²² report a systematic and critical review of the efficacy of purely school based child sexual abuse prevention programmes. They searched the literature published between 1990 until 2005, and identified 22 studies for inclusion, the latest of the included studies were published in 2001. Studies did not have to have a comparison group, but did have to include outcome measurement. Key outcomes included personal safety knowledge, self protection skills, emotional impact, perception of risk, changes in disclosures, maintenance of gains and negative programme effects. Over the 14 studies for which an effect size could be calculated, the mean effect size was 0.61 – a moderate effect size. Negative effects were reported in half the studies, these were mostly small in number, mild in nature and of short duration. The authors report poor quality in many studies, acknowledge the difficulties of research in this field and conclude that the positive results reported in the better quality studies provide some encouragement – but are not sufficient to warrant whole-hearted endorsement of the programmes without further research. They identify guidelines from examining the programmes with larger effect sizes and four or more outcome gains – concluding that modelling, discussion and skills rehearsal are crucial programme components, and that programmes should also be at least 4-5 sessions long, have the capacity to be delivered by a range of personnel and involve active parental input.

There is also evidence supporting whole school approaches at primary school level for behaviour improvement, including bullying and abuse prevention: with staff training on educational and communication styles; prevention policies, including improved nutrition and physical exercise (NICE 2008)²³. There are potential roles in delivering these for a wide range of public sector professionals

¹⁹ Hartman, J.L., Turner, M.G., Daigle, L.E., Exum, M.L. and Cukken, F.T. (2009) 'Exploring the gender differences in protective factors: implications for understanding resiliency', *International Journal of Offender Therapy and Comparative Criminology*, 53(3): 249-77.

²⁰ Hass, M. And Graydon, K. (2009) 'Sources of resiliency among successful foster youth', *Children and Youth Services Review*, 31: 457-63.

²¹ Prof JA Blackmore; Prof AR Taket; A/Prof CJ Hickey; Dr AC Nolan; Mr BJ Marshall; A/Prof KE Stagnitti; Prof RC Carter. Interagency collaborations supporting resilient students, families, schools in disadvantaged communities, LP0990128 ARC Linkage

²² Topping, K. J. and Barron, I. G. (2009) 'School-Based Child Sexual Abuse Prevention Programs: A Review of Effectiveness', *Review of Educational Research* 79(1): 431-63.

²³ NICE (2008) Promoting children's social and emotional wellbeing in primary education: NICE public health guidance 12, London: National Institute for Health and Clinical Excellence. The evidence reviews on which this are based, available on the NICE website are:

(for example health visitors, school staff or police) as well as the voluntary and community sector. Complementary to programmes aimed at children are those aimed at parents in terms of parent education programmes, fostering development of warmth, positive regard, empathy, the use of clear and consistent boundaries and positive discipline (NICE 2008). Since the publication of this guidance, further studies reinforce the value of such school based programs. One such is as the 'Zippy's Friends' program, in use in a wide range of countries, which is designed to promote the emotional wellbeing of children aged 5 to 8 by increasing their repertoire of coping skills. An RCT evaluation of implementation in disadvantaged areas in Ireland found that the program significantly improved children's emotional literacy and coping skills, reduced hyperactivity levels and improved relationships in the classroom (Clarke and Barry 2010)²⁴.

At secondary school level, again evidence also exists supporting whole school approaches to support social and emotional wellbeing (NICE 2009)²⁵. Within Victoria, Flood et al (2009)²⁶, examine one part of such approaches namely those focused on respectful relationships. Their review identifies five criteria for good practice: a whole-school approach; a program framework and logic; effective curriculum delivery; relevant, inclusive and culturally sensitive practice; and finally impact evaluation. They identify some very good violence prevention and health relationships programs operating in Victorian secondary schools, however most do not involve a whole-of-school engagement, have short durations, and lack substantive evaluation.

Primary prevention –programmes outside school

Most out of school prevention programmes target at risk children or families. One exception is described by Dubowitz et al. (2009)²⁷, who report encouraging results from an RCT of a primary care based preventive programme that produced significantly lower rates of child maltreatment on a number of measures, but more extensive evaluation is required.

Programmes targeted at high risk groups include: home visiting programmes; pre-school enrichment programmes; protective skill training for abuse prevention for children at high-risk for abuse, (e.g. looked after children, disabled children, families experiencing domestic violence); training of professionals in contact with children in order to identify abused children to refer for protection,

Adi Y et al (2007) Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools Report 1: Universal approaches which do not focus on violence or bullying. Coventry: University of Warwick.

Adi Y et al (2007) Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools Report 3: Universal Approaches with focus on prevention of violence and bullying. Coventry: University of Warwick.

Shucksmith J et al (2007) Mental wellbeing of children in primary education (targeted/indicated activities). Teeside: University of Teeside.

²⁴ Clarke A M, Barry M M (2010) An evaluation of the Zippy's Friends emotional wellbeing programme for primary school in Ireland. Galway: Health Promotion Research Centre, National University of Ireland.

²⁵ NICE (2009) *Promoting children's social and emotional wellbeing in secondary education: NICE public health guidance 20*, London: National Institute for Health and Clinical Excellence. The evidence reviews on which this are based, available on the NICE website are:

Blank L et al (2008) Systematic review of the effectiveness of universal interventions which aim to promote emotional and social wellbeing in secondary schools. Sheffield: School of Health and Related Research, University of Sheffield,

²⁶ Flood, M, Fergus, L, Heenan, M (2009) Respectful Relationships Education Violence prevention and respectful relationships education in Victorian secondary schools. Melbourne: Department of Education and Early Childhood Development

²⁷ Dubowitz, H., Feigelman, S., Lane, W. and Kim, J. (2009) 'Pediatric Primary Care to Help Prevent Child Maltreatment: The Safe Environment for Every Kid (SEEK) Model', *Pediatrics*, 123(3): 858-64.

therapy and protective skill training; early identification of abusive behaviour, for example, conduct disorder, in children for additional pro-social skills and parenting programme interventions.

Hahn et al.'s (2003)²⁸ systematic review concludes that there is sufficient evidence of the effectiveness on early childhood home visiting in reducing child maltreatment (physical, sexual, or emotional abuse; physical, emotional, or educational neglect; or a combination of abuse and neglect) in families at risk for maltreatment, including disadvantaged populations and families with low-birthweight infants. Macmillan et al.'s (2000)²⁹ review reaches similar conclusions (although expressed somewhat more cautiously), and a later review by Gonzalez and MacMillan (2008)³⁰ clarifies that while most programmes targeting at-risk families have not shown evidence of effectiveness in preventing abuse or neglect³¹, there were two exceptions, the Nurse Family Partnership and the Early Start programme (a summary of these two is presented in the Table).

Successfully targeting at-risk families

	Nurse Family Partnership	Early Start programme
Country	United States	New Zealand
Provided by	Nurses	Nurses and social workers
Provided to	First time socially disadvantaged mothers	Family with 2 or more risk factors
Beginning	Prenatal, before end of second trimester	Postnatal, before 3 months after birth
Programme length	During pregnancy and 2 years after birth	As soon after birth as possible until child aged 3
Programme intensity	Visits weekly for first four weeks, then fortnightly for remainder of pregnancy. Weekly for first six weeks after birth, then fortnightly until child aged 21 months, then monthly until age 2 years	Dependent on family need
Programme activities	1. Promoting health pregnancy, health and development of child and parent's life course 2. Assisting women in building relationships 3. Linking women and family with health and social services	Comprehensive assessment of family needs, resources and strengths, followed by collaborative generation of solutions to family challenges (partnership between home visitor and client)
Evaluation follow-up	Over 15 years	Over 3 years
Outcomes compared to control group	<ul style="list-style-type: none"> • Improvements in women's prenatal health behaviours and pregnancy outcomes • Children - higher intellectual functioning, lower behavioural problems, less emotional vulnerability and language delays • Rates of child abuse and neglect reduced in first two years postpartum for highest risk women • Fewer deaths aged 0-9 from preventable causes • Reduction in maltreatment at 15 year follow up (not at 4 years) • Presence of intimate partner abuse reduced programme effects on maltreatment, but not on maternal or child functioning 	<ul style="list-style-type: none"> • Children had greater contact with primary health care (doctors and dentists) and less likely to have hospital visits for injury or ingestion • Higher rates of positive and non-punitive parenting at 36 months • Lower rates of severe child assaults • No differences in family related outcomes including maternal health, family functioning, exposure to stressful life events, economic circumstances

Source: Itzin et al (2010) page 46, summarised from Gonzalez and Macmillan 2008

According to Macmillan et al. (2000), evidence remains inconclusive on the effectiveness of a comprehensive health care programme, a parent education and support programme, or a

²⁸ Hahn, R.A., Bilukha, O.O., Crosby, A., Fullilove, M., Liberman, A., Moscicki, E., Snyder, S., Tuma, F., Schofield, A., Corso, P. and Briss, P. (2003) 'First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation: findings from the Task Force on Community Preventive Services', *Morbidity and Mortality Weekly Report Recommendations and Reports*, 52(14): 1-9.

²⁹ MacMillan, H.L. (2000) 'Preventive Health Care, 2000 update: prevention of child maltreatment', *Canadian Medical Association Journal*, 163(11): 1451-58.

³⁰ Gonzalez, A. and MacMillan H. L. (2008) 'Preventing child maltreatment: an evidence-based update', *Journal of Postgraduate Medicine* 54(4): 280-6.

³¹ It is important to note here that there are many other studies of supportive services provided to at risk families, but these stop short of including the measurement of change in abuse and or neglect following the receipt of services, and for that reason were excluded from our consideration in terms of the VVAPP.

combination of services in preventing child maltreatment. Sure Start local programmes in the UK, designed to improve the health and wellbeing of children living in disadvantaged neighbourhoods do not directly target abuse, but they do contain factors known to be protective or promotive of resilience, among their outcome variables. Some encouraging results have emerged from the evaluation of the fully established Sure Start programme (Melhuish et al. 2008)³² in terms of positive effects on five out of fourteen outcomes: children's social development; children's social behaviour; children's independence; less negative parenting; and better home learning environment. Melhuish et al. (2007)³³ analyse the data further to examine whether variations in the programmes account for the differences in child/family functioning, and find modest links between implementation characteristics, including empowerment of parents, and effectiveness for child and parenting outcomes. This provides helpful information to guide future programme design. Most recently Melhuish et al (2010)³⁴ argues that ongoing research and development of Sure Start has resulted in improved impact over time.

The VVAPP systematic literature review could identify no studies that examined the efficacy of screening for child abuse. MacMillan et al.'s (2000)³⁵ review of literature on the prevention of child maltreatment found that screening approaches used to identify families at high risk for child maltreatment generated high false-positive rates and high risk of mislabelling people as potential child abusers. Parental education and support programmes led to a decreased number in reports of child abuse and neglect. Programmes aimed primarily at preventing sexual abuse of children, by increasing awareness and improving safety skills, have been shown to improve children's knowledge of sexual abuse and enhance their awareness. However, none of the studies examined actually determined the effectiveness of programmes in reducing the incidence of sexual abuse or abduction. Two further reviews of screening for child abuse have been published since the conclusion of the work for VVAPP, a systematic review determine the clinical effectiveness of screening tests for physical abuse in children attending accident and emergency (A&E) departments in the UK³⁶, and a systematic review of screening for child abuse at emergency departments³⁷. Neither of these found evidence to recommend screening.

³² Melhuish, E., Belsky, J., Leyland, A. H., Barnes, J. and the NESS Research Team (2008) 'Effects of fully-established Sure Start Local Programmes on 3-year-old children and their families living in England: a quasi-experimental observational study', *Lancet* 372(9650): 1641-47.

³³ Melhuish, E., Jay, B., Anning, A., Ball, M., Barnes, J., Romaniuk, H., Leyland, A. and the NESS Research Team (2007) 'Variation in community intervention programmes and consequences for children and families: the example of Sure Start Local Programme', *Journal of Child Psychology and Psychiatry*, 48(6): 543-51.

³⁴ Melhuish, E., Belsky, J., Barnes, J (2010) 'Evaluation and value of Sure Start', *Archives of Disease in Childhood*, 95: 159-161.

³⁵ MacMillan, H.L. (2000) 'Preventive Health Care, 2000 update: prevention of child maltreatment', *Canadian Medical Association Journal*, 163(11): 1451-58.

³⁶ Woodman, J., M. Pitt, et al. (2008) 'Performance of screening tests for child physical abuse in accident and emergency departments.' *Health technology assessment* 12(33): iii, xi-xiii 1-95.

³⁷ Louwers, E. C. F. M., Affourtit, M. J. et al. (2010) 'Screening for child abuse at emergency departments: A systematic review.' *Archives of Disease in Childhood* 95(3): 214-218.

Secondary Prevention – working with children who display sexually inappropriate behaviour

The research that exists (Hackett 2004; Whittle, Bailey and Kurz 2006)³⁸, as well as expert opinion, supports the adoption of broad-based behavioural and developmental goals, with the use of a cognitive behavioural framework, and attention to the resolution of the child's own abuse experiences. Work that includes the non-abusing parent is also supported. Interventions that are supportive and empathic, and tailored to the developmental stage of the child are important; these need to pay careful attention to the child's unique constellation of experiences that have shaped their presenting behaviour. Attention was particularly drawn to the need to recognize learning disability in formulating treatment strategies, and the importance of relating planned interventions to stage of development.

³⁸ Hackett, S. (2004) What works for children and young people with harmful sexual behaviours? Barkingside: Barnardo's.

Whittle, N., Bailey, S. and Kurz, Z. (2006) The needs and effective treatment of young people who sexually abuse: current evidence, London: Department of Health and Home Office.