Rapid review on safeguarding to inform the Healthy Child Programme 5 to 19

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1. Introduction

Summary of key points

1. The purpose of this rapid review is to update the evidence in relation to safeguarding guidance in the Healthy Child Programme for 5 to 19 year-olds.
2. It synthesises evidence about 'what works' in prevention and early intervention as regards child abuse and neglect, child sexual abuse and exploitation, intimate partner violence (IPV), female genital mutilation (FGM) and gang violence.
3. Focusing on the period 2006 to 2015, a total of 27 systematic reviews and 9 additional randomised controlled trials (RCTs) are included.
4. Key messages on identifying families in need of additional support, the effective implementation of interventions, and workforce skills and training are also included, as is evidence on the economic aspects of safeguarding.

An excutive summary of the report and a short overview of the key findings has been produced as well as an appendices document which provides technical information on the searches and data tables.

1.1 Background

The Healthy Child Programme (HCP) for 5 to 19-year-olds sets out the good practice framework for prevention and early intervention services in England for children and young people aged 5 to 19 years. It recommends how health, education and other partners working together across a range of settings can significantly enhance children and young people's life chances (DH and DCSF, 2009). It is aimed at children's services practitioners across the range, including:

- health service providers (such as school nurses, GPs, Child and Adolescent Mental Health Services (CAMHS))
- education providers (teachers and school staff with specialist health and wellbeing roles, such as Personal, Social and Health Education (PSHE) and special educational needs, and Further Education staff),
- wider services for children and young people (including youth workers, youth justice services and the voluntary sector)

The HCP for 5 to 19-year-olds focuses on several areas including:

- addressing key health priorities (including health inequalities, emotional and mental health, healthy weight, managing long-standing illness/disability, teenage pregnancy and sexual health, and drugs, alcohol and tobacco);

- the need for regular health and development reviews
- programmes for screening and immunisation
- signposting services
- promoting environments that promote health
- supporting parents and carers
- safeguarding

The safeguarding element is designed to translate into practice in 2 ways. At the individual level, practitioners need to possess relevant knowledge and skills (for example, regarding risk factors and signs and symptoms of child abuse, and how to follow local safeguarding procedures). At the institutional level, the emphasis is on sharing information and collaborating with other agencies; for instance, schools are expected to work closely with adult services to identify children with parents whose needs could put the child at risk (owing to chronic substance misuse, poor mental health, domestic violence and so on).

The present HCP for 5 to 19-year-olds is based on the evidence available at the time of the last update in 2009. The evidence has developed since then, especially in relation to safeguarding, with particular issues such as child sexual exploitation not included in the current version. Similarly, the commissioning and service delivery landscape has changed significantly with the reorganisation of the health system and increased commissioning responsibilities for local government in respect of the HCP for 5 to 19-year-olds. It is important that local authorities, working with their local partners, are aware of the latest evidence.

Public Health England (PHE) therefore commissioned a rapid review of the latest evidence in relation to the safeguarding elements of the HCP for 5 to 19-year-olds to ascertain if there is a need for the evidence/practice to be updated. It is envisaged that the completed review will inform the commissioning and service delivery of the HCP and the practice of individual practitioners with regard to safeguarding children and young people. The work will inform the partners on the Children's Health and Wellbeing Partnership (CHWP), which was formed by the Department of Health and its partners to bring together key national organisations accountable for policy, commissioning and delivery to improve children and young people's health outcomes. It is envisaged that the review will inform both the overall service delivery of the HCP and the practice of individual practitioners.

The present review complements the new National Institute for Health and Care Excellence NICE) guidance on child abuse and neglect (NICE, 2017) and the recent Early Intervention Foundation report on improving the effectiveness of the child protection system (Molloy et al., 2017). The latter draws in part on a review of 'what works' to improve outcomes for children who have experienced abuse and neglect or are clearly identified as being at risk of abuse (Schrader-McMillan and Barlow, 2017).

These related documents cover a wider age range (including the under-5s) and have a different focus; in particular, unlike the present review they do not include universal prevention and they do cover children who are experiencing or have experienced abuse and neglect. This report – specifically Chapter 3 – also complements recent PHE publications on child sexual exploitation (PHE, 2017a/b), which cover a wider range of literature both in terms of focus – beyond the effectiveness of prevention and early intervention – and types of study – beyond systematic reviews and RCTs.

1.2 Aim of the review

The purpose of this rapid review is to update the evidence in relation to safeguarding guidance in the HCP for 5 to 19-year-olds. To do this, the review seeks to synthesise relevant systematic review level evidence about 'what works' in the following key areas:

- child abuse and neglect
- child sexual abuse and exploitation
- IPV
- FGM
- gang violence

Searches were undertaken for systematic reviews published since the last review of this evidence for the HCP (2006). Since important studies of intervention effectiveness may not be in the systematic reviews, particularly if they have been published subsequently, an additional search was undertaken for RCTs published in the respective subject areas but not captured in the systematic reviews.

In addition, the review aims to draw out key messages in relation to:

- identifying families in need of additional support
- the delivery/effective implementation of interventions at programme/service level and individual practitioner level
- workforce skills and training
- the economic value/cost benefits of the HCP, including both health and wider societal costs.

Many of the reviews that were identified include studies of varying methodologies and quality, so the level of rigour of the included studies and the confidence that can be attached to the findings is reflected in a critical appraisal of each review (contained in the data extraction tables in Appendices B and C). A significant proportion of the systematic reviews covered a wider age range than is of interest for this review. In such cases, and where possible, efforts are made in this review to disaggregate these findings by identifying which constituent studies include children aged 5 to 19 years.

Where this is not possible, suitable health warnings are given regarding interpretation of the evidence.

In line with the focus of the HCP for 5 to 19-year-olds, the review focuses on prevention and early intervention (that is, promotion, universal prevention, and selective prevention).[1] Studies have been excluded if they focus primarily on interventions to address the consequences of maltreatment, notably those designed to ameliorate or mitigate the impact of safeguarding failures (for example by working with survivors of child sexual abuse, or addressing stress and trauma symptoms in children exposed to domestic violence). Some type of studies were excluded, including studies that:

- are not published in English
- that extend beyond the focus of the review on promotion, universal prevention and selective prevention
- do not clearly cover any part of the 5 to 19 years age range, or which cover only a small part of the age range of interest as part of a wider age range (for example 0 to 5s)
- duplicate other included reports published in another form (for instance an article in a peer-reviewed journal that is essentially a summary of a Cochrane review)
- are earlier versions of a subsequently updated review that is included (such as a Cochrane review from 2010 that was updated in 2014)
- are hard to access (commonly PhD dissertations and conference proceedings)
- are literature reviews but which do not explicitly use a systematic review approach
- are on preventing youth violence that do not explicitly focus on preventing gang-related youth violence
- are in a location with poor applicability to the UK (reviews were prioritised where a clear majority of the included studies were conducted in high-income countries)[2]

1.3 Methods

To identify suitable systematic reviews, relevant databases were searched, including those of key organisations (notably Cochrane Collaboration, NICE, EPPI Centre, Campbell Collaboration) and key electronic health, social science and education databases (such as PubMed, PsycINFO, ASSIA, Web of Knowledge and Google Scholar). The following inclusion criteria were used:

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[1] These 3 levels may be summarised simply as follows: (1) *Promotion* – providing universal services to promote good outcomes; (2) *Universal prevention* – providing universal services to prevent poor outcomes; (3) *Selective prevention* – selecting and intervening with individuals or population sub-groups at elevated risk of poor outcomes (see Chapter 3 of O'Connell et al., 2009).

[2] The exception is Chapter 5 on FGM, as no systematic reviews or primary studies meeting the inclusion criteria and on this subject could be identified in high-income countries.

- study design (systematic reviews and reviews of reviews)
- years (2006 onwards)[3]
- outcomes (related to the list of topics in section 1.2 above)
- population (children aged 5 to 19 and/or their parents/carers, and focusing on promotion, universal and selective prevention)

Experts in the respective fields covered by the review were consulted and asked to identify any systematic reviews that were not identified by the search of electronic databases.

Studies that met the inclusion criteria were critically appraised to assess their quality. This focused on issues such as:

- whether the review addressed a clear question
- how comprehensive a search was undertaken
- the type of studies included and whether their quality was assessed
- what results are presented
- whether those results apply to the UK

Other data extracted included:

- a description of the interventions being reviewed
- a description of the review findings
- a summary of the authors' conclusions
- messages regarding the identification of families in need of additional support, effective implementation and workforce skills and training
- authors' recommendations for future research

A more detailed description of the search and review process is provided in Appendix A, and data extraction tables for the systematic reviews are in Appendix B.

A total of 27 systematic reviews were included. Many more potentially suitable papers were identified but they were excluded for one or more reasons (see section 1.2 above). Suitably qualified and trained researchers (all members of the team except GB, who focused on the economic analysis in Chapter 7) undertook data extraction and critical appraisal for the included studies, using bespoke guidance to supplement their existing knowledge and experience. To help ensure consistency and accuracy, a

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[3] Effectively covering the 10-year period 2006-2015. The original search and review work was completed mid-2015. In order to check that the findings of this review are up-to-date, a subsequent search for systematic reviews took place in April 2017 prior to report sign-off. This led to the addition of 2 extra systematic reviews published later in 2015, and suggested that the conclusons of a small number of relevant reviews published since then do not contradict – and indeed are broadly in line with – the conclusions of this report (for details see Appendix A).

proportion (c.10%) of completed data extraction forms were completed by 2 researchers and then compared. Reviewers also received comments on their reviews (from NA and KL) and were asked to make amendments accordingly – both to those reviews and others where similar issues arose. All completed data extraction forms were read by at least 2 members of the team and, in some cases, amended further after checking the original source.

A similar procedure operated in the search for and appraisal of RCTs, except that the timeframe was dependent on the publication date of the most recent systematic review in the specified topic area. The earliest RCT search was from 2007 and extended to the time when the main search was completed (mid-2015). A total of 9 RCTs were included and reviewed. A different data extraction and critical appraisal form was used for the RCT studies. Among other things, this included an appraisal of the research question, randomisation procedures and the blinding of data collectors. The data extraction tables for the primary studies can be found in Appendix C.

In the cases of both the systematic reviews and primary studies, the standard searches were supplemented with suggestions from experts, focusing on the first authors of the systematic reviews included and other acknowledged experts in the respective fields. A total of 37 experts were contacted, yielding 23 responses and 101 referred papers. After screening these for relevance against the inclusion and exclusion criteria, and after removing duplicates of studies that had already been identified through the standard search process, 7 new studies (4 systematic reviews and 3 RCTs) were added.

The review also considered the economic aspect of safeguarding. Specifically, for relevant interventions that focus on 5 to 19-year-olds for which the Dartington Social Research Unit (DSRU) had already conducted a cost-benefit analysis,[4] the review includes additional information about how effects on relevant short-term outcomes, such as child abuse and neglect, result in monetary benefits from change in longer-term outcomes, such as reduced costs of treating depression. The review has also examined meta-analyses conducted by the Washington State Institute for Public Policy (WSIPP) that analyse the effects of child abuse and neglect in the 5 to 19 age range on longer-term outcomes. Details from a selection of the studies in these meta-analyses are used to illustrate these relationships.

Finally, an expert advisory group provided comments on a draft of the report, and experts in the respective subject areas reviewed the critical appraisal and interpretation of findings to help ensure that the results presented accurately reflect the available evidence.[5]

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[4] See www.investinginchildren.eu
[5] See the Acknowledgements section for a list of the people who contributed in these ways.

Before proceeding to the findings, it is important to acknowledge the limitations of the review. First, it focuses on relevant systematic review level evidence of intervention effectiveness and relevant RCTs not included in those reviews. As such, it does not include other types of evidence, such as non-systematic reviews, implementation or process studies or impact evaluations that do not employ randomisation to generate a control group. Second, as a 'rapid review', it does not provide the level of detail and critical scrutiny of studies usually found in full systematic reviews (although it arguably provides considerably more than is found in some other rapid reviews). Third, by virtue of what the included systematic reviews and primary studies examine, the review focuses more on interventions than on public health strategies. Many of the interventions reviewed fit a public health model in the broad sense of determining risk factors for a problem, developing interventions to address those risk factors and then implementing and monitoring those interventions on a population basis. This approach may be contrasted with a forensic approach of diagnosis and establishing culpability once abuse has occurred. However, without denying their importance, the review says little about whole-population universal strategies for preventing child maltreatment, such as legislation against smacking, reducing child poverty and improving support for parents (see, for example, Woodman and Gilbert, 2013). Fourth, although attention in the review is mainly on studies in high-income countries, there is no guarantee that interventions found to be effective in one country will transfer internationally in terms of implementation and/or impact. There may be various reasons for this, including cultural factors and the relative strength of services as usual in the respective locations. Fifth, the review does not critique the systematic reviews it covers in terms of what studies they included or how they represented those studies. Lastly, findings from some studies and programmes may be overrepresented because systematic reviews in similar subject areas inevitably include data from the same studies. The findings should be read with these points in mind.

1.4 Order of what follows

The findings of the review are ordered thematically, as follows:

- preventing child abuse and neglect
- preventing child sexual abuse and exploitation
- preventing intimate partner violence (IPV)
- preventing female genital mutilation (FGM)
- preventing gang involvement and gang violence
- economic analysis

Each of chapters 2 to 6 first summarises the systematic review level evidence of the subject area in question and then, where relevant, summarises the evidence from additional primary studies. Key messages from the systematic reviews regarding

implementation issues, identifying families in need of additional support and workforce development (recruitment, training, supervision) then follow. A summary section at the end of each chapter draws the findings together and highlights research recommendations. A short bullet-pointed summary of intervention effectiveness is provided at the start of each chapter, while each chapter ends with a bullet-pointed list of relevant implications for policy and practice.

1.5 Summary

The HCP for 5 to 19-year-olds sets out the recommended framework of universal and progressive services for children and young people to promote their optimal health and wellbeing. The purpose of this rapid review is to update the evidence in relation to the guidance on safeguarding.

To do this, the review synthesises relevant systematic review level evidence about 'what works' in relation to child abuse and neglect, child sexual abuse and exploitation, IPV, FGM and gang violence. In line with the remit of the HCP for 5 to 19-year-olds, the focus is on prevention and early intervention. Searches were undertaken using key electronic databases for systematic reviews published in the period 2006 to 2015. An additional search was undertaken for RCTs published in the respective areas but not captured in the systematic reviews. Experts were also consulted. A total of 27 systematic reviews and 9 additional RCTs were included. Studies were critically appraised and key data relevant to the study aims were extracted.

As well as summarising evidence of intervention effectiveness, the review aims to draw out key messages in relation to:

- identifying families in need of additional support
- the effective implementation of interventions
- workforce skills and training

It also considers the economic aspect of safeguarding. It analyses the effects of child abuse and neglect in the 5 to 19 years age range on longer-term outcomes, and explores whether effects on short-term outcomes, such as child abuse and neglect, result in monetary benefits from change in longer-term outcomes, such as reduced costs of treating depression.

Studies that met the inclusion criteria were critically appraised to assess issues such as:

- whether the review addressed a clear question
- how comprehensive a search was undertaken
- the type of studies included and whether their quality was assessed

- what results are presented and whether those results apply to the UK

Other data that were extracted included:

- a description of the interventions being reviewed
- a description of the review findings;
- a summary of the authors' conclusions;
- messages regarding the identification of families in need of additional support, effective implementation and workforce skills and training
- authors' recommendations for future research

The review has several limitations. It does not include implementation or process studies or impact evaluations that do not employ randomisation to generate a control group. Findings from some programmes and studies may be overrepresented if they appear in more than one systematic review. Further, while this review focuses mainly on studies in high-income countries, there is no guarantee that what works in one country will transfer internationally in terms of implementation or impact.

2. Preventing child abuse and neglect

Summary of key points

1. The evidence for universal campaigns with a population-level mass media component designed to prevent child physical abuse is mixed. There is evidence from several studies of a positive impact on outcomes such as increasing parents' knowledge of child development and community resources, reducing dysfunctional and coercive parenting and increasing community involvement in safeguarding. However, the evidence of effectiveness in terms of reducing child maltreatment is more limited.
2. There is evidence that parenting programmes (some universal, but mostly targeted) can prevent actual child maltreatment, although the evidence is stronger for their impact on reducing relevant risk factors and strengthening protective factors (for example improving parents' attitudes towards abuse, and reducing coercive child-rearing behaviours). This is partly because actual abuse is not always measured in studies of such programmes, but also because when it is measured there is not necessarily a positive effect.
3. Targeted family-focused interventions are effective in improving different aspects of family functioning that are related to child abuse and neglect, such as parents' child management skills and families' skills in regulating negative emotional states.
4. The limited evidence available suggests that universal school-based interventions to reduce cyber-abuse are ineffective in increasing children's online protective behaviours, although they have some positive effects on internet safety knowledge and attitudes.

2.1 Introduction

Recent research into the prevalence of child maltreatment and other types of victimisation among children suggests that actual rates of abuse are higher than those reported in official UK statistics (Radford et al., 2013). A UK-wide study found that 2.5% of children under 11 years and 6% of young people aged 11 to 17 had one or more experiences of physical, sexual or emotional abuse, or neglect, by a parent or caregiver in the past year. It also found that 8.9% of children under 11 years, 21.9% of young people aged 11 to 17 years, and 24.5% of young adults (18 to 24 years) had experienced this at least once during childhood (Radford et al., 2013). This presents a very pressing public health concern.

Drawing on a wide body of literature, Berry et al. (2013) offer the following definitions of different types of child abuse and neglect: "Physical abuse refers to non-accidental physical injury inflicted on children, for example through hitting, shaking, burning,

suffocating or drowning. Emotional abuse […] is captured by the mental injury inflicted on children through patterns of interaction that indicate the child is worthless, flawed, unloved or unwanted. Sexual abuse has been defined as using superior strength and/or resources to make a child engage in undesired sexual behaviour. Neglect concerns the omission of care, where caregivers fail to provide adequate supervision, physical and emotional nourishment, or medical care" (p.178). More detailed definitions can be found in Working Together to Safeguard Children (HM Government, 2015, pp.92-93), while Chapter 3 of this report provides a more detailed definition of child sexual abuse.

Although the nature and extent of impairment following child maltreatment varies, suggesting that some people are more resilient than others (Afifi and MacMillan, 2011), it is recognised that adults who have been exposed to childhood abuse or neglect are at increased risk of behavioural, emotional and social problems (including delinquency, depression, suicide ideation, chronic illnesses and post traumatic stress disorder) (Hildyard and Wolfe, 2002; MacMillan et al., 2007; Radford et al., 2013). From a public health perspective, these health trajectories are particularly concerning given the links between these outcomes and various physical health problems (Widom et al., 2012). Therefore, while research is increasing knowledge of various ways to enhance resilience in these children (Collishaw et al., 2007), there remains a clear case for prevention and early intervention (Radford et al., 2013), not least because intervening post-abuse is increasingly difficult and costly (Kilburn and Karoly, 2008).

This chapter reviews the effectiveness of interventions designed to prevent child maltreatment, and highlights issues in relation to the implementation of interventions. A total of 9 systematic reviews were identified summarising the effectiveness of interventions addressing child abuse and neglect. There were no additional randomised controlled trial (RCT) studies. It will be seen that many of the reviews report on proposed mediators of intervention effect, such as increasing parental self-efficacy or reducing parental anger, which may not necessarily lead to the prevention or reduction of actual child maltreatment. Studies that focus exclusively on child sexual abuse and sexual exploitation are covered in Chapter 3 of this report.

2.2 Systematic reviews

Poole et al. (2014) reviewed the effectiveness of universal interventions with a population-level mass media campaign component aimed at preventing child physical abuse and corporal punishment and delivered via various forms of mass communication or in community services with wide population access. This component was delivered through various means, including TV, radio, billboards, posters, report cards or community services (notably schools and hospitals). The populations targeted included the general public, adults aged over 18 years, caregivers and parents of children of a specific age (ranging from newborns to 18 years old). All studies included in the review were conducted in high-income countries (US, Australia, UK, New Zealand, Canada

and Japan), with interventions implemented at various scales geographically, including national, state, county/district and city/town. There were 17 studies in total, including 7 RCTs (pre-post, time series and survey designs were also included). Six of the 17 focused specifically on Shaken Baby Syndrome (SBS), which lies outside the scope of the current review on the basis of the age group covered. The outcomes measured were parental behaviours, attitudes, beliefs, knowledge and intentions.

A narrative summary of results was presented. Child physical abuse outcomes were measured in 3 studies, 2 of which are relevant here (the third focused on very young children). One, which evaluated the entire Triple P parenting programme (that is, all levels), found a statistically significant reduction in child maltreatment injuries and child maltreatment cases.[6] The other study reported a 98% decrease from pre- to post-campaign in the incidence of child abuse reports (no comparison group).

Regarding other aspects of parental behaviour change, which could be potential mediators of intervention impact on abuse (measured in 11 studies), positive effects were seen in terms of:

- reduced dysfunctional or coercive parenting
- increased calls to helplines to report child abuse cases
- an increased number of callers wanting to seek assistance from a helpline or report parental alcohol and drug abuse
- an increased number of attempts by parents and/or community members to prevent child abuse through strategies promoted in the campaign (such as assisting parents by providing child minding or babysitting)

Changes in parental attitude were more mixed, with only one of 7 studies identifying a statistically significant and positive improvement post intervention. Increased parental knowledge was reported in the areas of child development and community resources (knowing where to get information about parenting). Studies also found improvements in parenting self-efficacy and competence and reductions in parental anger or frustration. One study reported increased intention to use appropriate and positive child discipline strategies. It is important to note that 5 studies (4 RCTs and one non-equivalent groups design) included in this review involved Triple P: 2 examined the entire Triple P programme and 3 examined the universal Level 1 media component only. Statistically significant improvements in parents' beliefs, knowledge, emotions and/or behaviours were seen in all 5 studies, and one reported significant reductions in child maltreatment injuries and cases (see above). Key significant findings included:

- decreases in child problem behaviours

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6 Triple P is a tiered programme, ranging from universal media strategies (Level 1) to group or individual sessions targeted at parents of children with problem behaviours (Levels 4 and 5).

- decreases in dysfunctional parenting
- increases in parental self-efficacy

Although the review identified some positive results, its authors concluded that "the evidence base for universal campaigns designed to prevent CPA [child physical abuse] remains inconclusive due to the limited availability of rigorous evaluations; however, Triple-P is a notable exception" (p.388). They recommended that such campaigns be developed further and evaluated rigorously given their potential to shift population norms relevant to CPA and reduce rates of CPA. In terms of future research, the authors recommended that more rigorous evaluations are conducted to strengthen the evidence base for this type of intervention, particularly given their potential for community-level impact, and that future evaluation studies should incorporate clear descriptions of programme theory and identify the targeted risk factors and how they link with programme messages and components. In this context, it is noteworthy that many programmes targeted known risk factors such as parental impulsivity, the stigma of asking for help, inadequate social support, inappropriate expectations for a child's developmental stage, and lack of knowledge regarding positive parenting techniques, but were unable to link this to any evidence of programme effectiveness on behaviours (Poole et al., 2014).

Mikton and Butchart (2009) reviewed universal and selective child maltreatment prevention interventions (age not further specified). Interventions included parent education programmes, media-based interventions, universal child sexual abuse prevention programmes and multicomponent interventions involving family support, parenting skills, pre-school education and childcare.[7] The outcomes measured included physical abuse, sexual abuse, neglect, or emotional abuse perpetrated by a parent or caretaker against a child. This study was a review of reviews, containing data from 26 systematic reviews, which summarised 298 outcome evaluations and 85 reviews and commentaries. All of the outcome studies were from high-income countries (mostly the US), with the exception of 2 studies from China and Colombia respectively. In terms of method, the included studies in the reviews comprised 140 RCTs, 82 non-RCTs,[8] 45 studies with no control group, 9 studies classed as 'other' (including time-series, surveys, or qualitative designs), 4 studies where the design was unclear, and 18 where no design was identified. The studies measured child maltreatment directly (for example reports from child protection services) or indirectly using proxy measures (for example Accident and Emergency visits, hospitalisation for injury), as well as risk factors for maltreatment (such as child abuse potential, parent stress) and protective factors (such as knowledge of sexual abuse and protective behaviours).

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[7] The review also covered home visitation programmes and abusive head trauma (also referred to as Shaken Baby Syndrome), but in both cases by definition the target age-group falls outside the scope of the present review.
[8] Effectively quasi-experimental design (QED) studies, that is, the studies have a control group but it is not formed through random allocation.

A narrative summary showed that evidence for parent education programmes (typically centre-based, in groups) was mixed, with 2 meta-analyses out of the 7 reviews in this category reporting small-to-medium effect sizes on the basis of both risk factors and direct measures of child maltreatment, while other studies in the category found positive effects on the risk factors for child maltreatment but insufficient evidence of effectiveness in terms of preventing or reducing actual child maltreatment. Child sexual abuse prevention programmes, delivered in schools, consistently showed effectiveness for strengthening protective factors (such as knowledge of sexual abuse and protective behaviours) but evidence for whether they reduce actual sexual abuse was deemed to be lacking (see Chapter 3 for more evidence on this type of programme). Evidence for the effectiveness of multi-component interventions (typically including services such as family support, childcare, pre-school education, and parenting skills training) in terms of reducing risk factors for child maltreatment was found to be mixed, insufficient or promising in 3 reviews respectively. One meta-analysis found a medium effect size of 0.58 for this type of intervention. Two out of 3 reviews of media-based interventions found mixed or insufficient evidence for their effectiveness, while the other one identified a large effect size for the reduction of risk factors for child maltreatment (see above for the more recent review of such interventions by Poole et al., 2014).

Overall, the authors concluded that "Four of the seven types of universal and selective interventions examined in the 26 reviews are promising for preventing actual child maltreatment: home visiting [in early childhood – not relevant for this review], parent education, abusive head trauma prevention [for young children – again, not relevant for this review] and multi-component programmes […] The evidence, in relation to actual child mistreatment, on the 3 remaining types – child sexual abuse prevention, media-based interventions, and social support and mutual aid groups – is either insufficient or mixed" (pp.357-358). The authors were critical of the large volume of poor quality studies they identified: "Cumulative knowledge on child maltreatment prevention is ill served by an ever increasing accumulation of methodologically questionable studies" (p.358). Accordingly, they noted that the conclusions they draw about effectiveness are tentative owing to methodological weaknesses of both the reviews and the studies included in them. This informs their major recommendation, namely that studies are conducted with higher methodological rigour and measure actual maltreatment outcomes.

Klevens and Whitaker (2007) reviewed universal and targeted preventative and therapeutic interventions aiming to prevent the occurrence of child physical abuse, neglect or unspecified child maltreatment. Approximately one-third of the interventions included in the review operated at the universal level, with the other two-thirds targeting a high-risk population, and about four-fifths were concerned with physical abuse and/or neglect. The identified interventions were implemented in various settings, including the home, community centres, health centres and schools and through the mass media. There was no information in the review about the countries in which studies were

conducted or the age range covered, although it can be inferred from the settings that some of the interventions targeted school-aged children and their parents. Information about the type of intervention included was not provided in a systematic way, but there were references to home visiting, parent training and community-based initiatives among others. Just over half (51%) of the 188 reports included in the review had no evaluation component. The remainder employed a range of evaluation methods, including (in order of volume, from high to low): RCT, one group pre-post measure, non-equivalent groups, controlled trial, one group post-measure, time series / regression analysis and process evaluation. The studies reported on the following categories of risk factor: individual (low level of education, unwanted pregnancy, parenting skills and so forth); family (for example stress, family conflict/ partner violence); neighbourhood (relating to child care and access to services amongst others); and societal (social tolerance of abuse). Some of the studies also measured abuse, although details about how they did this were not provided.

A narrative summary of the results was presented. Fewer than a quarter (n=46) of the evaluated programmes met the authors' criteria of 'rigorous evaluation'. Of these, 17 measured the impact on child maltreatment, with 9 showing reductions. An additional 20 programmes measured the impact on one or more of the targeted risk factors, with 18 reporting reductions in the risk factors targeted. The review also found that while almost all of the risk factors were targeted, efforts to modify some were very limited; these included teenage pregnancy, cognitive inflexibility,[9] attributional biases,[10] social skills deficits, harsh discipline, family conflict and partner violence, poverty, lack of social cohesion, fragmented services, and social norms tolerating violence toward children.

The authors concluded that, owing to the fact that only about a quarter of the programmes included a rigorous evaluation, "the effectiveness of a majority of primary prevention programs for child maltreatment is still unknown" (p.370). They added that, as only 3 programmes specifically targeted neglect, there is a need for more programmes to address neglect. They also argued for more interventions to target the 4 neglected risk factors with high prevalence in the general population (teenage pregnancy, partner conflict, poverty and social norms tolerating violence toward children), on the basis that doing this will generate a higher impact at the population level than targeting less prevalent risk factors. The authors further argued from a cost-containment perspective for the value of interventions "delivered by the public or to the public or that require the least effort by recipients" (p.372). The review identified very few evaluated interventions in these categories (examples included Sweden's ban on corporal punishment, a home visiting programme for all mothers, an informational card or video for expectant parents, and a one-hour didactic session for high school

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9 In parent-child relationships, cognitive flexibility relates to the parent's ability to adapt to parenting challenges rather than following a rigid set of rules.
10 This refers to parents' biased interpretations of their own or their children's behaviour.

students). Accordingly, the authors called for the further development and rigorous evaluation of similar interventions, including community-level interventions that aim to increase social cohesion or community organisation, and efforts to enhance the availability, coordination and integration of social services needed by families and children. Finally, they recommended that evaluations should measure child maltreatment and other related health outcomes until the link between risk factors and outcomes is known with greater certainty.

Lundahl et al. (2006) reviewed the effectiveness of parent training programmes targeted at parents either convicted for or at risk of perpetrating child abuse (physical, emotional and neglect but not sexual abuse). They identified 23 studies, including pre-post evaluation designs (n=17), studies comparing treatment and comparison groups (n=4) and studies comparing 2 treatment groups to one comparison (n=2). No information was provided about the age group covered or the countries in which studies were conducted.[11] Programmes were delivered to a group or an individual, sometimes supplemented with home visits (there was no information about who delivers the programmes). Interventions were categorised as behavioural, non-behavioural or a mixture,[12] and were divided between those with a low (≤12 sessions) or high (≥13) number of sessions. The 4 reported outcomes were actual documented abuse and parents' emotional adjustment, child-rearing skills and attitude towards abuse. The measures used were frequently standardised, and included parent self-report, observations and documentation (rates of recidivism and state records indicating assessing the need for further monitoring or care).

A meta-analysis found that immediately after training "parents evidenced moderate, but significant, positive gains in all outcome constructs" (p.255). Studies with a stronger methodology found lower effect sizes. Attitudes and child-rearing behaviours improved with the addition of home visitors and when training took place in the home and office, rather than just in the home. Increasing the number of sessions and combining group and individual modes improved attitudes but not behaviours. Specifically, parents who completed training were more likely to rely on non-coercive strategies, such as the expression of warmth and democratic reasoning, and less likely to rely on coercive strategies, such as physical force or threats. Follow-up assessments were rare but, when conducted, showed that desirable changes in parents' attitudes remained stable, and that while gains in parent emotional well-being and child-rearing behaviours fell by 40% they remained meaningful.

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11 Reference to home visiting suggests that at least some of the interventions were with children younger than the age-group of interest for the present review.

12 *Behavioural* programmes seek to change parents' behaviour such that children's pro-social behaviours receive positive reinforcement while their aversive behaviours are consistently punished or ignored. *Non-behavioural* programmes tend to emphasise communication styles and promote an authoritative parenting style.

The authors concluded that "parent training is effective in reducing the risk that a parent will physically abuse, verbally abuse, or neglect a child" (p.258). They recommended that parent training is delivered in both group and individual settings, and that it includes some home visiting to help parents to individualise the lessons learnt in training classes. In addition, they advised that parent training should include both behavioural and non-behavioural components to promote positive outcomes. In terms of future research, the authors recommended seeing if the results hold where there are documented cases of abuse, suggested that studies need to differentiate more between different types of abuse, and called for studies that investigate the influence of pre-defined programme characteristics to inform programme design.

Barlow et al. (2006) undertook a systematic review of reviews that included evaluations of targeted interventions to prevent child physical abuse and to reduce or ameliorate abuse and neglect. The inclusion criteria for the review as regards participants were parents at risk of abusing or who had already abused or neglected their children. The review identified 15 systematic reviews, which included relevant RCTs, quasi-experimental design studies (QEDs), controlled and uncontrolled studies, meta-analyses of mainly non-randomised designs, comparative studies, mixed method studies, and studies of unspecified design. It is unclear exactly where the included studies took place, although the authors' conclusions noted that many were outside the UK and that the programmes had been adapted for use in a UK context. The review included 3 main types of interventions relevant to 5 to 19 year-olds:[13]

1. Parenting programmes, which were delivered either on a one-to-one basis or in groups with the aim of changing parenting practices, and aimed at high-risk parents or at-risk families (parents who have abused their children or are at risk of becoming abusive).
2. Intensive family preservation services (IFPS) in which families at risk of out- of-home placement receive intensive support.
3. Social support and other family support interventions that aim to increase social support or mutual aid for parents through informal networks or media interventions.

Study results were synthesised in a narrative summary. Reported outcomes for parenting programmes included parenting practices, basic childcare, safety, nutrition, problem-solving, positive parent-child interactions and behaviour management. There was a moderate overall impact, with a large effect on parental knowledge, a moderate effect on parent behaviour and a small effect on parent attitude. Evidence of the impact of parenting programmes on objective measures of child abuse and neglect was

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[13] Home visiting programmes were described but are not included here because they tend to target the families of very young children (many such interventions commence antenatally or during the immediate postnatal period) and are therefore beyond the remit of this report (see Axford et al., 2015a/b for reviews of home visiting programmes). Also not included here are early multi-component community-based interventions, typically comprising family support, preschool education or childcare and community development, as they also appear to be for families with younger children.

deemed inadequate, in part owing to the lack of long-term follow-up. Studies of IFPS were unable to demonstrate an effect on out-of-home placements owing to the problem of surveillance bias but there was reasonable evidence of them improving a range of outcomes associated with abuse and neglect, including parent and family functioning and children's conduct and delinquency. Family-focused interventions were found to be effective in improving different aspects of family functioning that are related to child abuse and neglect, such as parents' child management skills and families' skills in regulating negative emotional states. Multi-systemic Therapy was found to be more effective than behavioural interventions for family functioning but not parenting behaviours or parental mood. Overall, the most effective interventions (both 'targeted' [selective] and indicated) comprised multiple components that were flexible and capable of addressing the different facets of abusive and neglectful parenting. The more effective parent-focused interventions included home visiting [arguably less relevant for the age group covered by the present review] and behavioural parent training combined with cognitive behavioural therapy to help regulate parents' negative emotional states.

The authors concluded that "there is considerable scope for preventing many of the problems associated with abusive and neglectful parenting through the implementation of early interventions aimed at improving parenting practices and through intervening with parents who have abused or neglected their children with a view to improving outcomes such as parenting practices" (p.26). Specifically, they argued that there is "some evidence to support the use of parenting programmes based on approaches such as cognitive behavioural therapy, parent-child interaction therapy and other well-recognised models such as the Webster-Stratton Incredible Years series to improve some aspects of parent, child and family functioning, both preventively and therapeutically" (p.24). However, they also noted that the evidence for their impact on objective measures of child abuse and neglect is inadequate, in part owing to the lack of long-term follow-up, and argued for more research into intervention cost-effectiveness and cost-benefit.

McCloskey (2011) reviewed parenting programmes aiming to reduce abuse and neglect in families with children aged 0 to 17 in high-income countries. A total of 22 RCTs were included. Participants in all studies were aged under 12 years (11 included children aged 5 and above, meaning that age-wise they are relevant for this report). The interventions aimed variously to change parental attitudes, modify parenting behaviours or attitudes associated with abuse, reduce parental stress, improve general parenting knowledge and skills, reinforce positive relationship dynamics, reduce coercion, and in some cases reduce child conduct problems associated with abuse histories. The interventions were implemented by a range of providers, including psychologists, case managers, mental health professionals, therapists and paraprofessionals, and were mostly delivered weekly over 6 to 16 weeks in homes or clinics. Sessions tended to last around 1 to 2 hours. These interventions targeted parents who were abusive or at risk of being abusive. The majority of parents were low-income mothers with less than a

high school education. Outcomes reported were parent self-report of child abuse potential, parent-child relationship, parenting practices and attitudes. In terms of risk behaviour, child maltreatment or harsh parenting were measured, and close correlates of abuse were also measured, namely parenting stress, style and attitudes (to child-rearing, harsh punishment and the parent's child).

The results were presented in the form of a narrative summary. Of the 11 studies in the review that focused on the relevant age group, only the 7 concerned with preventing abuse in the first instance are reported on here (the others focused mainly on preventing the reoccurrence of child abuse, which lies beyond the remit of the present review). Fathers attending a fathers' group showed increased engagement with their child but there was no effect on parental stress or parenting attitudes. Methadone-maintained parents had reduced parenting stress due to the Parents Under Pressure intervention. Triple P was found to be effective for reducing abuse reports, out-of-home placements and injuries, although the expanded version (which added anger management and attributional re-training) showed no further advantages. Incredible Years was found to have positive significant effects on parent-child interaction, positive discipline, co-parenting, harsh parenting and the home environment. SOS reduced self-reported abuse.

Taking into account all studies, including those involving children aged under 5 years (such as home visiting), those focusing on preventing the re-occurrence of abuse (such as more therapeutic approaches), and those within scope for the current review (see above), the authors concluded that most programmes yielded encouraging results, although a third reported no differences between intervention and control groups on abuse-related measures. As such, they stated that "some findings strongly support parenting interventions; others raise questions about their value" (p.36). Home visiting programmes, which are less relevant for the age-group covered by the present review, were the least effective in terms of their impact on child abuse rates. The programme referred to above which seeks to transform men into compassionate fathers showed modest improvements in the parent-child relationship and was deemed by the review authors to hold great promise in addressing gender-based violence. The only research recommendation concerned the need for more uniform measurement in the field.

Chen and Chen (2016)[14] conducted a systematic review and meta-analysis of the effectiveness of parenting programmes in reducing child maltreatment and modifying associated factors. They identified 37 studies (all RCTs) that met their criteria, covering 31 parent training or home visiting programmes with a focus on child maltreatment. The studies were mostly conducted in developed countries (the US, Canada, Australia, New Zealand and England), with 2 from developing countries (Thailand and Iran). Study quality was deemed to vary significantly. The programmes were a mix of primary,

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14 This study was published with advance online access in early 2015, hence its inclusion here (focus period 2006-2015).

secondary and tertiary prevention: 32% of participants were recruited without any observation or detection of abuse; 61% were parents at risk of child maltreatment; and 7% of parents had substantiated abuse behaviours. There was little other information in the review about the nature of the programmes. Given the focus of the present review, it is important to note that the majority of parents in included studies were under 30 years old, with children under 5 years old,[15] so interpretation of the results and conclusions needs to take this into account.

A meta-analysis including all outcomes – reduction in maltreatment, risk factor reduction and protective factor enhancement – found an overall effect size of 0.296. Parenting programmes were found to reduce substantiated and self-reported child maltreatment reports, the potential for child maltreatment and risk factors associated with child maltreatment (notably harsh or dysfunctional parenting and inappropriate parenting attitudes) and to enhance relevant protective factors (such as positive parenting). Positive effects were identified for primary, secondary and tertiary interventions. A moderator analysis was conducted to examine the heterogeneity in study effect sizes. This found that some programme characteristics, namely dosage, early start (in or before the pre-natal period) and participant type, contributed to between-group variance, but others did not (service delivery method, the involvement of home visitors, and the qualification of the intervener). The authors concluded that "parenting programs are effective public health approaches to reduce child maltreatment" and "[t]he evidence-based service of parenting programs could be widely adopted in future practice" (p.88). They advised that more attention should be paid to improving parents' mental health, since the effects on reducing depression and stress – parents' inability to manage these is a risk factor for child maltreatment – were limited, and that future studies should explore, *inter alia*, longer-term impact, moderators of effectiveness and the mechanisms underlying successful programmes.

Euser et al. (2015) also reviewed programmes for parents designed to prevent or reduce child maltreatment. They were interested in interventions for the general population, families at risk for maltreatment and families already identified as maltreating. They included 23 studies (all RCTs) covering 27 independent samples and all measuring actual maltreatment. It is not clear exactly where studies took place although the large majority (85%) were from the US. The focus of programmes varied but included support (social, emotional, material) and/or training in parenting skills, and their delivery format included centre-based groups and/or personal home visits. They were all delivered by (para)professionals. Seven of the 27 papers included children in the age-range of interest for the present review (that is, 5 to 19 years), and 21 targeted the general population or at-risk families (again, the focus of the present review). However, the limited overlap between these 2 categories means that only 3 of the 27

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15 No further information about the ages of participants is provided.

studies are directly relevant here,[16] which should be taken into account when reading the study results and conclusions.

A meta-analysis involving 20 programmes found a small but statistically significant combined effect on maltreatment (d=0.13) but this disappeared after adjustments were made to take into account publication bias against smaller studies without significant outcomes. (None of the 3 studies referred to above showed a statistically significant effect.) This led the authors to conclude that "intervention programs have no overall significant effects on the reduction or prevention of child maltreatment" (p.12). However, they also conducted moderator analyses, which showed that larger effect sizes were found for certain study types (more recent studies, and those with smaller samples) and programmes with certain features (those providing parent training instead of only support, those targeting maltreating instead of at-risk families and those with a moderate length (6 to 12 months) or a moderate number of sessions (16 to 30)).

Since some other reviews have suggested that interventions in this area are promising, Euser et al. (2015) sought to explain why their results appear to present "a gloomy picture" (p.1). One reason they gave is their focus on measures of maltreatment *per se* rather than risk factors, noting that some programmes are effective in reducing the latter but not the former. They also pointed out that in some trials effects are found for sub-groups but not the whole randomised sample. In terms of future research, the authors recommended more RCTs, especially in the area of prevention: "Results of our meta-analysis indicate that so far intervention programs are only effective in reducing child maltreatment, and thus only protect children when the harm has been done" (p.12). They also advised that studies take child maltreatment as their primary outcome measure, report separately on different types of maltreatment (most studies to date have included either an overall measure or focused on one type only – usually physical abuse) and include longer-term follow-ups.

In the final systematic review covered by this chapter, Mishna et al. (2011) reviewed interventions aiming to prevent cyber abuse[17] by providing children and young people with preventive education designed to increase their knowledge of internet safety and decrease their risky online behaviour. The 3 interventions included in the review were universal, delivered in school settings by teachers or a researcher, and involved sessions lasting 40 to 50 minutes delivered over 1 to 6 weeks. Participants were aged 10 to 14. The studies all used a pre-post design with a control group (non-random allocation) and took place in the US or Canada. The outcomes measured by the review were participants' internet safety knowledge, behaviours and attitudes and cyber bullying activity.

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16 These 3 studies were of programmes targeting families 'at risk', although it is not specified whether these constituted selective or indicated prevention.

17 Cyber abuse was defined as "online abusive interpersonal behaviors including online bullying, stalking, sexual solicitation, and problematic exposure to pornography" (Mishna et al., 2011, p.5).

Effect sizes were reported for each study. Overall, results were mixed. In the case of the 'I-SAFE' cyber safety programme, a comparison of effect sizes for the intervention and control groups indicated a positive impact on participants' knowledge but no impact on inappropriate online behaviours. The 'Missing' cyber safety programme reduced the likelihood that children would reveal personal information online but did not have effects on the majority of attitudes and behaviour. With regard to the HAHASO anti-bullying programme ('Help, Assert Yourself, Humor, Avoid, Self-talk, Own it'), all but one effect size was negative, indicating that the control groups had more changes between pre-/post-test than treatment groups, although no results were statistically significant (at $p<0.05$). Other findings were that pupils receiving interventions were more likely to discuss online safety with friends, which may increase the likelihood of online issues being shared and thus risks being identified earlier.

The authors concluded that "participation in psycho-educational Internet safety interventions is associated with an increase in Internet safety knowledge but is not significantly associated with a change in risky online behavior" (p.5). They argued that more research is needed to understand the link between internet safety knowledge and risky online behaviour, as the link between psychosocial interventions and risky online behaviour is unclear. They also advocated conducting research on younger children than those included in the studies that were reviewed, and called for exploration of opportunities to reduce risk through blocking programmes and software filtering.

2.3 Primary studies

No additional primary studies meeting the criteria were identified.

2.4 Implementation issues

In terms of intervention duration and intensity, there appears to be an association in many studies between effectiveness and duration, with longer and more intensive studies reporting larger effect sizes than shorter programmes (Barlow et al., 2006). The review of parenting interventions by Lundahl et al. (2006) found that a higher number of sessions was associated with greater changes in parent attitudes linked to abuse, albeit it not to child-rearing practices, suggesting that the former may be more difficult to change. Based on their findings about how effectiveness is moderated by programme duration and number of sessions (see above), Euser et al. (2015) argued that for at-risk or maltreating parents "somewhat more comprehensive programs with longer duration may be needed in order to effectively change parenting behaviour. At the same time, our results indicate that programs should not provide services for too long" (p.11).

Many reviews stressed the importance of adapting interventions for the context, in other words adjusting content to reflect the local constraints and challenges (for example

McCloskey, 2011). This includes cultural adaptation specific to ethnicity, and adaptation to the target group's developmental stage (Poole et al., 2014).

A review of the effectiveness of parent training programmes in reducing parents' risk of abusing their children found that interventions appear to benefit from being implemented in a combination of settings (Lundahl et al., 2006). When implemented in homes, interventions seem to provide parents with more emotional support and an opportunity to individualise the lessons they have learned in group training. In addition, it is suggested that one-on-one support may provide time and space for parents to work on changing attitudes and beliefs. The same review suggested that programmes should include behavioural and non-behavioural elements, because programmes with behavioural principles showed more positive changes in parental behaviour compared with those that did not, whereas non-behavioural programmes were more successful in changing parental attitudes linked to abuse.

Chen and Chan (2016) found that programmes involving fathers achieved a lower effect size than those where mothers were the sole participants. This led them to suggest that parenting programmes may need to be modified to suit fathers given their (fathers') important role in parenting and the parent-child relationship.

2.5 Workforce skills and training

A general message across reviews was that interventions are more effective when there is collaboration between professionals, services and other providers. More should be done to further improve and join up these services.

Some effective interventions required specific training and qualifications in the relevant skills. Examples include Parent-Child Interaction Therapy, which requires implementers to be trained as a therapist, or cognitive behavioural therapy (CBT), which also needs to be administered by trained professionals (McCloskey, 2011). The improved implementation of online security interventions depends on parents/caregivers and teachers being better-educated and more adept at using technology and the internet (Mishna et al., 2011). This helps them to appropriately identify and challenge unsafe online behaviours. While interventions delivered in schools may have considerable reach and access to the target population, they can suffer because teachers, who most commonly implement such interventions, lack the skills and expertise needed to deliver them effectively.[18] All this said, Chen and Chan (2016) found that intervention effectiveness was not moderated by the qualification of the intervener.

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18 It is possible that other school staff, such as school nurses or counsellors, may be better placed to do this, although this is not explicitly mentioned in the studies reviewed.

2.6 Identifying children and young people in need of additional support

None of the systematic reviews in this chapter focused explicitly on identifying children in need of additional support, and there is a wider literature on this subject (see, for example, Allnock and Miller, 2013; Cossar et al., 2013). Nevertheless, there are relevant comments in 2 of the studies. First, the review by Barlow et al. (2006) of interventions to prevent or ameliorate child physical abuse and neglect suggested that comprehensive family assessments should be administered to families at risk to identify negative interactions in the first instance. It added that this should be followed by a tailored, flexible and multi-component intervention to reduce risks to child welfare, such as programmes that combine both home visiting and centre-based services for children with additional social support. Second, the Mishna et al. (2011) review of interventions to prevent cyber abuse highlighted that when pupils receive the cyber safety interventions they are more likely to discuss online safety with friends, which may make it more likely that online issues will be shared and thus risks identified earlier. The authors also recommended that if children at risk or in need of additional support are to be identified effectively, then parents, caregivers and teachers need to be better educated regarding technology and the internet, and need to engage more with children who use these resources.

2.7 Summary

The evidence for universal interventions that have a population-level mass media component is somewhat mixed. There is evidence from several studies of a positive impact in terms of outcomes such as increasing parents' knowledge of child development and community resources, reducing dysfunctional and coercive parenting and increasing community involvement in safeguarding. This is promising, because these outcomes might all be considered to be mediators of intervention impact on actual abuse. However, the evidence of effectiveness in terms of reducing child maltreatment is more limited (only measured in a couple of studies relevant to the present review). On balance, then, and with the exception of the Triple P programme, for which the evidence was considered promising, the evidence base for universal campaigns with a mass media component designed to prevent child physical abuse remains inconclusive due to the limited availability of rigorous evaluations. However, the potential for such campaigns to shift population norms and reduce abuse means that they should be developed further and evaluated rigorously.

There is evidence that parenting programmes – both universal and targeting parents who are at risk of being abusive – can prevent actual child maltreatment, measured using objective indicators, although the evidence is arguably stronger for their impact on reducing risk factors and strengthening protective factors (for example reducing coercive child-rearing behaviours and improving parents' attitudes towards abuse). This

is partly because actual abuse is not always measured in studies of such programmes, but there is also some evidence that when it is measured there is not necessarily a positive effect. There is also evidence of parenting programmes having differential effects according to factors such as programme content or approach (skills training is better than support only), the degree of targeting (effects are stronger for families where abuse already exists) and intervention length. It is also important to note that there appear to be relatively few RCTs of universal or selective parenting programmes concerned with child maltreatment for children in the age group covered by the present review. This means that the evidence from reviews cited in this chapter draws heavily on interventions for parents of children aged under 5 years and/or on indicated interventions (that is, for maltreating parents), although attempts have been made to disaggregate results where possible.

It is suggested in some of the research reviewed that when a home visiting element is added to parenting programmes it provides parents with emotional support and helps them to individualise the lessons learnt in group sessions, although another review calls this into question and it may be less relevant to the age group of interest in the current review (that is, it arguably applies more where children are younger). Also, it is suggested in some of the studies examined that parenting programmes are most effective when they combine behavioural training with cognitive behavioural approaches to help parents to regulate their negative emotional states.

Targeted family-focused interventions were found to be effective in improving different aspects of family functioning that are related to child abuse and neglect, such as parents' child management skills and families' skills in regulating negative emotional states. IFPS have also been shown to improve family functioning, as well as parental reports of childcare and children's conduct, and there is also some evidence of their impact on maltreatment.

The limited evidence available suggests that universal school-based interventions to reduce cyber-abuse are ineffective in increasing children's online protective behaviours, although there were some positive effects on internet safety knowledge and attitudes.

Some general messages about the implementation of interventions emerge from the evidence reviewed, including the:

- need to adapt content to local context
- importance of assessment prior to intervention in the case of targeted interventions
- positive association that appears to exist between duration and effectiveness
- need for implementers to have appropriate training and support, particularly if intervention content lies beyond their usual range of expertise and experience

In terms of future intervention development, there is a need for programmes that specifically target child neglect, as few interventions do this despite it being the most common form of child maltreatment. Further, some risk factors for child maltreatment are neglected by existing programmes that seek to prevent child maltreatment; it is worth targeting those with a high prevalence (notably teen pregnancy, partner conflict, poverty and social norms that accept violence towards children), as this will likely have a disproportionately large impact. Parenting interventions could also be better at ensuring that fathers are suitably engaged and improving parental mental health (since parents' inability to manage depression and stress is a risk factor for maltreatment).

There is also a case for developing more community-level interventions that target social cohesion (see van Dijken et al., 2016) and for increasing the availability, co-ordination and integration of social support provision for children and families. Regarding population-level programmes with a mass media component, there is a need to further develop such campaigns and evaluate them rigorously given their potential to shift population norms relevant to child physical abuse and to reduce rates of such abuse. The theories of change of such approaches also need to be described clearly.

Several review authors were critical of the large volume of low-quality research they found. Accordingly, there is a general need for more rigorous effectiveness evaluations in the field, notably the use of control groups. As regards to further research, there is also a need for:

- more common measures of outcomes across studies to facilitate the synthesis of the evidence
- the measurement of intervention cost-effectiveness and cost-benefit
- the measurement of programme impact on actual child maltreatment and related health outcomes (that is, not only factors associated with maltreatment)

Evaluations of parent training interventions need to differentiate more between the impact on different types of maltreatment (physical, emotional, sexual and neglect) and investigate the influence of pre-defined programme characteristics (to inform programme design). Regarding school-based interventions to prevent cyber abuse, more research is needed on:

- the link between internet safety knowledge and risky online behaviour (as the link between psychosocial interventions and risky online behaviour is unclear)
- the impact of interventions on younger children (under-10s)
- and the impact of blocking programmes and software filtering

Implications for policy and practice

1. Universal interventions with a population-level mass media component have the potential to shift population norms relevant to, and reduce rates of, child physical abuse. As such, they deserve to be implemented more widely while recognising the need further develop and evaluate them. Although evidence of their impact on actual physical abuse is inconclusive owing to the limited availability of rigorous evaluations (Triple P being an exception), they can impact positively on relevant aspects of parental behaviour.

2. Parenting programmes merit implementation as a means of preventing maltreatment, particularly on the basis of evidence of their impact on factors associated with maltreatment. However, further testing of their impact on objective measures of maltreatment is needed, as is attention to their design (given evidence that some approaches seem to work better than others).

3. Family-focused interventions and IFPS have both been shown to improve family functioning, so their implementation provides considerable scope for preventing some of the problems associated with child abuse and neglect.

4. Although the limited evidence to date suggests that universal school-based interventions to reduce cyber-abuse are ineffective in increasing children's online protective behaviours, the fact that they have been found to improve children's internet safety knowledge and attitudes suggests that they do warrant implementation but with further development and testing.

5. A general message is that implementers of interventions need to have appropriate training and support, particularly if the content lies outside their usual range of expertise and experience (which is not uncommon).

6. This review demonstrates that there is a pressing need for further intervention development. Few interventions specifically target child neglect, so there is a need to develop programmes that do this. Some risk factors for child maltreatment are neglected by existing programmes that seek to prevent child maltreatment, so it is worth targeting those factors with a high prevalence, as this will likely have a disproportionately large impact. Parenting interventions could usefully pay more attention to parents' mental health and the role of fathers. There is also a case for developing more community-level interventions that target social cohesion, and for increasing the availability, co-ordination and integration of social support provision for children and families.

7. As several review authors were critical of the large volume of low-quality research they found, further intervention development should be accompanied by more rigorous evaluation, including control groups, measures of intervention impact on actual child maltreatment and related health outcomes and longer-term follow-up.

3. Preventing child sexual abuse and exploitation

Summary of key points

1. Child sexual abuse takes different forms, so it is important to note that the results here may not apply equally to all of them. Also, this review did not identify any relevant studies focusing explicitly on preventing child sexual exploitation.
2. There is reasonably strong evidence from systematic reviews for the effectiveness of school-based sexual abuse prevention programmes in improving children's protective behaviours, perceived self-protection skills and knowledge about sexual abuse and how to be safe. The hallmarks of the more effective programmes include group discussion, modelling, skills rehearsal and a length of at least 4 sessions. Evidence for whether school-based programmes reduce sexual abuse is lacking.
3. There is a small amount of evidence for the effectiveness of interventions seeking to raise adults' awareness of child sexual abuse and helping them to recognise and respond to it. One of 2 primary studies focused on the general public, while the other targeted adults with formal caring responsibilities for children (referred to as 'childcare professionals'). The impact on actual abuse was not measured, but both studies found improved knowledge about child sexual abuse and one (for childcare professionals) found an effect on prevention behaviours (the other one found no effect).
4. A significant challenge for the field is determining whether changes in participants' knowledge and/or behaviours as result of child sexual abuse prevention programmes do actually reduce abuse *per se*.

3.1 Introduction

Child sexual abuse can be defined as when a child is forced or enticed to participate in sexual activities both physical and non-physical; they may not be aware that it is abuse or understand what is happening to them (NSPCC, 2015a). It covers a wide spectrum of crimes and offences (Finkelhor, 2009), which may: involve contact (such as unwanted touching, penetrative acts) or non-contact (for example exhibitionism, using children in the production of pornography); be perpetrated by adults or children; involve offenders who are either strangers or family members; and take place online or offline. Sexual exploitation is a specific circumstance where the sexual abuse is in exchange for something – commonly, but not exclusively, money, power or status (NSPCC, 2015b). The UK National Working Group for Sexually Exploited Children and Young People also formed a definition, which is now used for statutory guidance in England (HM Government, 2009): "Sexual exploitation of children and young people under 18

involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (for example, food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability" (p.9).

A recent UK-wide study found that 1.2% of under-11s, 16.5% of 11 to 17s and 24.1% of 18 to 24s had experienced sexual abuse, including non-contact offences, by an adult or by a peer at some point in childhood (Radford et al., 2013). Focusing only on the past year, these rates were 0.6% for under-11s and 9.4% for 11 to 17s.[19] The majority of perpetrators of sexual abuse were males, either adults or other young people, who were known to the child or young person. As regards sexual exploitation, an Inquiry by the Office of the Children's Commissioner into sexual exploitation in gangs and groups stated that 2,409 children and young people in England were confirmed victims of child sexual exploitation in gangs or groups in the 14-month period August 2010 to October 2011, and that between April 2010 and March 2011 there were 16,500 children and young people who were at high risk of child sexual exploitation (Berelowitz et al., 2012). As there are other forms of sexual exploitation, it is also important to be clear that the report in question offers only a partial picture of the extent of the problem. The report also advised that children in residential care are at elevated risk, and that the scale of abuse was likely to be much higher than what is reported. Nevertheless, collectively these figures present a challenge for interventions in their ability not only to prevent child sexual abuse (including sexual exploitation) effectively but also to identify and assist young people who are placed at further risk through such acts.

Child sexual abuse, of which child sexual exploitation is one form, is an area of particular concern in public health due to its widely documented long-term effects. Individuals who were sexually abused in childhood have been found to be disproportionately likely to have poorer physical health, altered brain architecture (decreased hippocampal volume, smaller corpus callosum, attenuation in the frontal cortex) with associated difficulties,[20] and severe psychosis (McClelland and Newell, 2013; Andersen et al., 2008; Bebbington et al., 2011). In addition, those abused as

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[19] Figures were not provided for the past year for 18 to 24 year-olds.
[20] The effects can include dramatic shifts in mood or personality (corpus callosum) and increased risk of developing PTSD-like symptoms and experiencing depression and physical inflammations (hippocampus) (Danese et al., 2008).

children are also more likely to lack help-seeking behaviours, such as accessing health services, due to the vulnerability – lack of trust and fear of losing anonymity – brought on by sexual abuse (McClelland and Newell, 2013). Further, victims of child sexual exploitation can face a range of difficulties, including isolation from family and friends, dropping out of education, unemployment, mental health problems, alcohol and drug addiction and criminal activity (Berelowitz et al., 2012). Its effect on families and communities can also be profoundly damaging.

To put the contents of this chapter into context it is helpful to note that there are various approaches to preventing child sexual abuse (Finkelhor, 2009; Zeuthen and Hagelskjær, 2013). First is offender management, for example, registering sex offenders and controlling where they live. Second are school-based curricula that teach children child sexual abuse concepts (such as body ownership, good/bad touch, appropriate and inappropriate secrets) and self-protection skills (including how to identify dangerous situations, refuse an abuser's approach, and summon help). Third, there is a growing trend for targeting potential abusers (for example via media campaigns) with messages that reinforce awareness that the behaviour is wrong and harmful and urging them to seek help (notably psychological treatment or via a confidential phone line). A fourth, related, approach entails mobilising third parties or bystanders (in particular family members, friends and colleagues of victims/offenders) to detect actual and potential abuse situations and intervene to protect children or report the situation. A fifth strategy is to target professionals, notably teachers, daycare providers and health workers, many of whom lack knowledge about the signs of child sexual abuse and reporting procedures. Sixth, parents can be targeted, although this is little used; for example, only some child-focused programmes have a parent element. A final element of a preventive model involves minimising harm, for instance via counselling or family interventions to alleviate victims' fears, anxiety, depression and negative self-attribution.

The focus of the present review on universal and selective prevention, together with the criteria for selecting relevant studies (systematic reviews and randomised controlled trials (RCTs)), mean that only 3 of the aforementioned approaches to preventing child sexual abuse are covered in this chapter, namely school-based curricula, mobilising community members and targeting professionals. The effectiveness of such interventions and issues regarding their implementation are reviewed. As already indicated, child sexual abuse can take different forms (contact/no contact, age at which it is experienced, online/offline, perpetrated by peers or adults, family members or strangers), and findings may not apply equally to all of them. It should also be noted that while some of the reviews covered in Chapter 2 do address sexual abuse, this chapter only includes studies that focus exclusively on sexual abuse. Finally, but importantly, no studies meeting the inclusion criteria were found that focus specifically on child sexual exploitation, and a note of caution is required because it is unclear to what extent studies in the systematic reviews included here addressed the particular complexities

associated with this form of abuse. Studies that concentrate on the subject of sexual exploitation and how to prevent it but which lie outside the scope of this review should be considered when formulating policy and practice recommendations (for a recent overview see Wurtele and Miller-Perrin, 2017).

3.2 Systematic reviews

Two relevant systematic reviews were identified, both of which examined educational curricula in schools. In the first of these, Topping and Barron (2009) reviewed school-based sexual abuse prevention programmes, focusing on interventions with efficacy evaluations (a control or comparison group was not required). They found 22 studies meeting their inclusion criteria (11 with a control group), evaluating 18 different programmes and targeting children aged 5 years and older. Most of the studies were of primary school children, weighted towards the younger end of the spectrum, and all were conducted in high-income countries – mostly North America and the UK but also Australia, New Zealand and other countries in Europe. Core themes included teaching children to recognise sexual and other types of abuse, to distinguish between appropriate touching, to tell the difference between good and bad secrets, to say 'no' or avoid unwanted approaches, and to tell an adult. All programmes included discussion, several involved modelling (such as plays and puppet shows) or interactive learning (notably role play and skills rehearsal), and a minority used other pedagogical elements (picture cards and abuse prevention songs amongst others). Most programmes were led by teachers (occasionally with trained facilitators present) but there were also a variety of other providers (including trained volunteers and school nurses).

A narrative summary of the results reported on 9 outcomes, including personal safety knowledge, self-protection skills, emotional impact, risk perception, touch discrimination, reported response to actual threat or abuse, changes in disclosures, maintenance of gains and negative programme effects. Most studies found a statistically significant increase in children's knowledge or awareness and/or abuse prevention (or self-protection) skills. Over a third of studies reported some emotional gain for participants (such as feeling safer and less worried). Only a few studies investigated participants' perception of risk (the ability to detect potentially hazardous situations), with mixed and inconclusive results. There was little evidence of change in disclosure, and limited follow-up evidence of the actual use and effectiveness of prevention skills (there was some evidence of the maintenance of knowledge). Negative programme effects were found in over half of the studies (mostly mild, short and small in number, and including fear, embarrassment and wariness of touch). Only 2 studies conducted analyses by socio-economic status, with both reporting worse outcomes for children from low socio-economic backgrounds: the first of these attributed the poorer outcomes[21] to parents of

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[21] The right to reject inappropriate touching and to report rude behaviour without being punished; having no trust of parents to stop the unwanted touching; and feeling they were not likely to be believed, because adults 'stick together'.

more disadvantaged children being less involved in school-based abuse prevention programmes and disadvantaged children fearing a very negative reaction from their parents to disclosure; the second study found that disadvantaged children did less well in self-esteem changes (but not skills and knowledge) but did not explore reasons for this. All programmes targeted reduced abuse but none could reliably and validly measure that outcome. Effect sizes were calculated where possible, which involved 11 studies and focused on child safety knowledge and perceived skills, with results showing overall modest average gains.

The review authors stated that most studies had methodological constraints, such as the use of unvalidated measures and a lack of data on implementation fidelity, and emphasised the patchy – and in some cases negative – findings. As such, they cautioned against concluding that "the continuation and extension of such programs may seem somewhat supported" (p.454). Instead, based on programmes that showed 4 or more gains and moderate-to-high effect sizes, they recommended that to enhance positive outcomes, future interventions should:

- incorporate modelling, group discussion and skills rehearsal
- be at least 4 to 5 sessions long
- have the capacity to be delivered by a range of personnel
- involve active parent input (although evidence for the latter was limited)

The authors called for studies of increased methodological quality and the greater use of RCT design studies to evaluate impact, with evaluation extending to longer follow-up times, particularly to assess whether some of the negative outcomes are transitory. They also recommended that future research should:

- pay more attention to fidelity and cost-effectiveness (none of the studies reported these)
- have larger sample sizes and include older children
- investigate the most protective core knowledge and skills
- assess the differential effectiveness of core themes (see above)
- test variations of aspects of delivery (length, provider, amount of training for providers, amount of parent involvement, and so forth)
- ensure that measures extend beyond knowledge to other areas (including other outcomes cited above)

The second systematic review (Walsh et al., 2015) also evaluated the evidence on school-based interventions to prevent child sexual abuse, focusing on children aged 5 to 18 years old and, unlike the previous review, only including RCTs. They identified 24 trials, including 7 RCTs, 11 cluster RCTs and 6 quasi-RCTs. All but one evaluated universal interventions delivered in primary school (4 to 11 year-olds) – the other was in a special school for adolescents with intellectual disabilities – and all were conducted in

high- and middle-income countries (US, Canada, China, Germany, Spain, Taiwan and Turkey). Intervention content took different forms, ranging from didactic approaches (such as a passively received talk or lecture) to more active approaches based on behavioural modelling (for example role play or practising self-protection skills). Interventions lasted from a single 45-minute session to 8 20-minute sessions on consecutive days, and were delivered by a range of people, including school staff (typically teachers, school nurses or school psychologists), external practitioners (for instance employees of a child protection agency) and volunteers.

A series of meta-analyses were conducted on 6 child-related indicators of programme effectiveness: protective behaviours;[22] knowledge of sexual abuse or sexual abuse prevention concepts; retention of protective behaviours over time;[23] retention of knowledge over time; harm from the intervention (measured in terms of anxiety and fear); and disclosures of sexual abuse. There was statistically significant evidence of effectiveness for the interventions on protective behaviours, questionnaire- and vignette-based knowledge, knowledge retention beyond the assessment, and disclosure of previous or current sexual abuse (although when adjusting for clustering, this latter effect became insignificant). There was no evidence that the interventions caused harm, using increased anxiety or fear in participants as an indicator. The authors concluded that the studies showed evidence of improvements in protective behaviours and knowledge among primary school children exposed to school-based programmes, regardless of the type of programme, and that there is evidence that children's knowledge does not deteriorate over one to 6 months post-intervention (although longer-term follow- up is needed). They stressed that these findings do not diminish adults' responsibility for ensuring children's safety, and that prevention strategies should not only target children but also work at the family, community and society levels to prevent it from occurring in the first instance. They advised that future research should be conducted and reported in line with evidence-based guidelines, such as the CONSORT statement (see Moher et al., 2010), and that follow-up times should be longer to monitor the long-term effects of interventions. They also recommended further investigation of the moderators of programme effects and longitudinal or data linkage studies to assess effectiveness in terms of the actual prevention of child sexual abuse. Finally, they called for more investigation of programme content, methods and delivery so that conclusions may be drawn about the ideal constellation of programme characteristics.

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[22] Protective behaviours include, for example, developing verbal responses (such as saying "No!" in a big voice) and 'motoric' responses (such as getting away, telling someone) in potential abuse situations.
[23] Three of the 24 included studies measured retention of protective behaviours over time. Complete data were not available for any of these studies and a meta-analysis could not be conducted.

3.3 Primary studies

A search for relevant primary studies not included in the systematic reviews yielded 2 papers, focusing on community mobilisation and adults with formal caring responsibilities for children respectively.

Rheingold et al. (2007) conducted an RCT to evaluate the effectiveness of a multimedia intervention that is part of a wider education and public awareness initiative to reduce the incidence and prevalence of child sexual abuse. The intervention was set in shopping centres across the US. Participants were subject to 2 30 to 60 second video-based public service announcements (PSA) aimed at raising awareness of the issue of child sexual abuse (including its prevalence and consequences). They also received an educational pamphlet containing information about the prevalence and consequences of child sexual abuse and skills to recognise it, decrease the risk of such abuse and respond when it is suspected.

Two hundred parents were randomised to one of 4 groups: the video group, the pamphlet group, the video and pamphlet control, or the no media control group. The study measured changes in adult's knowledge and attitudes about child sexual abuse and child sexual exploitation preventative behaviour. Results indicated that participants in the combined (PSA and pamphlet) condition had statistically significant higher knowledge scores at post-test than those in the no intervention condition (the 2 individual intervention groups had no significant effect compared to no-intervention). However, participants' knowledge of child sexual abuse decreased over time, so that the observed differences at post-test were no longer significant at the one-month follow-up. Regarding attitudes about child sexual abuse, there were no identified differences among intervention conditions post-intervention with regard to adherence to – or endorsement of – sexual abuse myths (a measure of attitude). However, for behaviour, in response to hypothetical vignettes participants in the pamphlet-only group reported a significantly greater mean number of primary prevention responses (such as discussing child sexual abuse with child, calling a hotline number, discussing such abuse with a child protection agency or the police) than the PSA and no intervention groups (again, these observed differences at post-test were no longer statistically significant at follow-up). There were no effects for other dimensions of (hypothetical) prevention behaviour. In addition, at follow-up, participants reported on actual engagement in prevention behaviours related to child sexual abuse in the month following the intervention, but there were no statistically significant differences between groups (possibly owing to insufficient statistical power).

The authors concluded that the intervention had a statistically significant effect on short-term knowledge, no significant impact on attitudes, and a significant impact on primary prevention responses to hypothetical vignettes but no impact on actual behavioural responses at follow-up. They suggested that this pattern is consistent with past

research demonstrating that public health media campaigns are effective tools for increasing knowledge about health-related information. They noted that although media campaigns alone may not sufficient to prevent child sexual abuse, even a small effect across a wide audience can have broad public health implications. They also recommended community-based training to complement a media campaign, suggesting that this may have a greater impact on attitudes and beliefs.

Rheingold et al. (2015) also conducted an RCT (n=352) in the US, this time to evaluate the effectiveness of an intervention designed to train adults with some caring responsibility for children – regardless of their level of training – in preventing, recognising and responding to child sexual abuse.[24] The intervention trained adults to be 'Stewards of Children' through either a single 2.5-hour workshop delivered at a child advocacy centre or interactive web-based training lasting over 2 weeks (comparable content and length as the in-person training). The intervention includes topics such as ways of minimising opportunities for child sexual abuse to occur, recognising signs of such abuse and appropriate responses when a child discloses it. Participants were from youth services organisations such as day care centres, churches and schools.

Participants were randomised to the workshop, web-based training or a waitlist control group. The outcome measures were child sexual abuse knowledge, attitudes (measured in terms of endorsement of associated myths[25]) and self-reported child sexual abuse prevention behaviours[26] in the previous 3 months (for example limiting the opportunity for an older and a younger youth to have one-to-one interaction, and sharing with another adult an article, brochure, or other information about the prevention of such abuse). Post intervention, child sexual abuse knowledge was significantly lower for the waitlist condition compared with the intervention,[27] and at the 3-month follow-up the overall level of knowledge remained higher for those who received the training (both conditions). There was no difference in prevention behaviours at post-test – the baseline for this measure – but at the 3-month follow-up participants who received the intervention reported more prevention behaviour than those allocated to the waitlist control. There were also positive effects favouring the intervention groups on attitudes, although the authors suggested that they may not be clinically meaningful because all groups scored low on the measure (indicating low acceptance of associated myths). There were no differences between the groups based on whether the intervention was delivered in person or via the internet.

The authors concluded that a brief training for childcare professionals may have an effect on child sexual abuse prevention knowledge and behaviour, but argued that the

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[24] Referred to in the study as 'childcare professionals', although participants included volunteers as well as teachers, day care workers, coaches, counsellors, probation officers, clergy and others.

[25] For example, "Children who do not report ongoing sexual abuse must want the sexual contact to continue".

[26] The measure referred to actual behaviours rather then requesting responses to hypothetical scenarios.

[27] The analysis combined participants in both the in-person and web-based training groups in one intervention condition.

practical implications are still unclear because it is premature to suggest that the intervention will yield clinically relevant shifts in the prevention of incidence or prevalence. They recommended that future work should focus on strategies for increasing the effectiveness of this programme, and argued that just as child-focused prevention is unlikely to protect children fully from this form of abuse, so adult-focused programmes are likely to be more beneficial when used in conjunction with evidence-based child-focused programmes. They added that adult-focused child sexual abuse programmes are needed as they can supplement the effects of child-focused programmes, not least because the latter cannot prepare children for the diverse approaches that potential offenders may use.

3.4 Implementation issues

Walsh et al. (2015) recommended that interventions in school should be part of a wider community initiative promoting child safety. They also recommended that involving parents in programme content and training teachers may be beneficial to increasing the community capacity for preventing sexual abuse.

Topping and Barron (2009) argued that school-based sexual abuse prevention programmes need to:

- incorporate modelling, group discussion and skills rehearsal
- be at least 4 to 5 sessions long
- have the capacity to be delivered by a range of personnel
- involve active parent input (evidence for the latter was limited) to have increased likelihood of effectiveness

They noted advantages of school-based programmes, for example that they are able to reach all children and raise awareness in salient peer and adult groups (including parents), and that they are located in a system that can offer continuity of support. A criticism of child sexual abuse prevention programmes delivered in schools cited by Mikton and Butchart (2009) – reviewed in Chapter 2 – is that they consistently report effectiveness for strengthening protective factors but not for reducing actual abuse.

3.5 Workforce skills and training

Walsh et al. (2015) suggested that the responsibility for reducing the risk of child sexual abuse rests with adults in the community, despite the fact that interventions invariably target children. They reinforced this with the suggestion that training teachers and involving parents in programme content may increase community capacity for sexual abuse prevention.

Topping and Barron (2009) cautioned that although access to school-based intervention is good, compared with clinical programmes they are likely to be briefer and involve less expert and less confident leaders.

3.6 Identifying children and young people in need of additional support

Walsh et al. (2015) suggested that children's social networks (community, society, family) should be closely monitored so that the early signs of abuse or intended abuse are picked up before any harm is caused.

3.7 Summary

Child sexual abuse takes different forms, and results from the studies in this chapter may not apply equally to all of them. Further, none of the studies in this chapter focuses explicitly on child sexual exploitation. Some caution is therefore needed in interpreting the findings summarised here.

There are various approaches to seeking to prevent child sexual abuse (of which child sexual exploitation is one form). In selecting studies that meet the inclusion criteria for this review, 2 broad types of intervention were identified: those targeting children, and those focusing on adults. To some extent, the adult-focused interventions help to address the criticism that school-based programmes put undue responsibility on children, although Finkelhor (2009) argues that equally it is "morally reprehensible" (p.182) not to equip children to take potentially effective action to prevent child sexual abuse. Indeed, in the public health and ecological systems models, it is acknowledged that child sexual abuse will only be eradicated if it is confronted on multiple levels, including child, family, community and society (Zeuthen and Hagelskjær, 2013).

The first type of intervention, covered by both systematic reviews, focuses on children's safety knowledge and skills and takes place in schools (mostly primary). There is reasonably strong evidence of the effectiveness of this approach in improving children's protective behaviours, perceived self-protection skills and knowledge about sexual abuse and how to be safe. Evidence of its effectiveness in terms of young people's ability to detect potentially hazardous situations is mixed and inconclusive, however, and there is little evidence that they increase the disclosure of sexual abuse. Some mild and likely short-lived negative programme effects were identified in one of the 2 reviews, such as fear, embarrassment or wariness of touch. Two studies, cited in the Topping and Barron (2009) review, found that the interventions were less effective for children from lower socio-economic backgrounds, perhaps, in one case, due to parents of more disadvantaged children being less involved in school-based abuse prevention programmes and disadvantaged children fearing that parents would react negatively to disclosure. Both reviews highlighted methodological weaknesses in the studies examined, and although programmes were mostly seeking ultimately to reduce actual

abuse, there was no evidence of impact on this outcome because it could not be measured reliably. These findings resonate with the conclusion of the review by Mikton and Butchart (2009), namely that school-based child sexual abuse prevention programmes consistently show effectiveness for strengthening protective factors (such as knowledge of sexual abuse and protective behaviours) but evidence for whether they reduce actual sexual abuse is lacking (see Chapter 2 of this report).

Given the methodological weaknesses identified and the somewhat patchy findings, one of the reviews (Topping and Barron, 2009) cautioned against simply continuing and extending existing programmes, and instead highlighted the hallmarks of the more effective programmes (notably the inclusion of modelling, group discussion and skills rehearsal, and holding at least 4 or 5 sessions). Recommendations for intervention development also included involving parents and providing teachers who deliver such interventions with more training. Elsewhere it has been pointed out that school nurses are rarely involved in school-based sexual abuse prevention programmes, even though they are well placed to help implement them (Fryda and Hulme, 2015). It should also be acknowledged that there is some concern in the field about the feasibility of fitting school-based child sexual abuse prevention into curriculum space that is already under pressure from a focus on academic attainment and programmes on other health-related issues (bullying, dating violence, suicide prevention and so forth). Accordingly, and given the frequent overlap in content between such interventions (many teach refusal skills, help-seeking, emotion management and decision-making), there is a case for developing and testing comprehensive prevention programmes that cover a range of issues (Finkelhor, 2009).

In terms of future research on school-based programmes, there is a clear need for more RCTs and for more studies to apply standardised and validated measures and to monitor implementation fidelity and cost-effectiveness. As already inferred, one of the main challenges for the field is determining whether changes in participants' knowledge and/or behaviours as result of child sexual abuse prevention programmes actually reduce abuse (Zeuthen and Hagelskjær, 2013). Evaluations of school-based interventions concerned with child sexual abuse prevention should also have longer follow-up times, particularly to monitor if some negative programme effects are transitory. Lastly, research is needed to work out which intervention components and themes are most important.

The second broad type of programme identified in the literature search focuses on adults. One approach involves mobilising community members, or the general public, to help prevent child sexual abuse. In the single study concerned, an RCT in the US, the intervention used the mass media – specifically, video-based public services announcements in shopping centres, and an educational pamphlet – to raise awareness amongst adults of the prevalence and consequences of child sexual abuse and how to recognise and respond to it. The evaluation found that it improved participants' short-

term knowledge and hypothetical behavioural responses to vignettes but had no impact on attitudes or actual behaviours. Another approach, also evaluated in a single RCT in the US, involved training adults with some formal caring responsibility for children – referred to in the study as 'childcare professionals' – in how to prevent, recognise and respond to child sexual abuse. This had a positive effect on participants' knowledge and prevention behaviours. Neither of the adult-focused studies measured intervention impact on the prevalence or incidence of abuse. However, it was noted in the earlier of the 2 studies that small effects at a population level can have broad public health implications, and that adult-focused interventions can usefully complement child-focused interventions.

Implications for policy and practice

1. In the public health and ecological systems models, it is acknowledged that child sexual abuse will only be eradicated if it is confronted on multiple levels, including child, family, community and society.
2. School-based interventions for children with a focus on safety knowledge and skills relating to child sexual abuse consistently show effectiveness for strengthening protective factors (such as knowledge of sexual abuse and protective behaviours), suggesting that they could play a valuable role in helping to prevent child sexual abuse. It is important that there is an emphasis on the hallmarks of the more effective programmes (notably the inclusion of modelling, group discussion and skills rehearsal, and holding at least 4 sessions), and that teachers who deliver such interventions receive more training.
3. The further development of school-based programmes should be accompanied by rigorous evaluation, particularly since evidence for whether they reduce actual sexual abuse is lacking (in large part because it is difficult to measure the outcome reliably). Given pressure on curriculum space and the overlap with content in programmes on other health-related issues, there is also a case for developing and testing comprehensive prevention programmes.
4. Interventions that mobilise adults, whether the general public or adults with formal caring responsibilities for children, to help prevent child sexual abuse are arguably an important complement to child-focused interventions. The small amount of evidence for their positive impact on participants' knowledge and, to a lesser extent, behaviour, highlights their potential value, particularly since small effects at a population level can have broad public health implications.

4. Preventing intimate partner violence (IPV)

Summary of key points

1. School-based (usually universal) dating violence programmes for adolescents are promising. There is reasonably strong evidence, mainly from North America, of their positive effects in terms of improved attitudes and increased knowledge around dating violence, and, although arguably not as strong, there is also evidence of their impact in terms of behavioural outcomes (notably victimisation/perpetration). Interventions that adopt a more comprehensive approach appear to be more effective. There is also evidence that dating violence prevention interventions delivered in the community (usually targeted) can be effective in reducing victimisation and/or perpetration, albeit with some variation.

2. Media campaigns may be useful in raising awareness of intimate partner violence (IPV) and services to address it, but their limited reach can be a potential barrier to their effectiveness. There is weak evidence from a small number of studies that information leaflets in healthcare settings can change knowledge and attitudes regarding IPV.

3. There is weak evidence that community-based interventions (home visiting for pregnant teenagers, and a clinic-based group for adolescent parents) improve various outcomes relating to IPV, including knowledge, skills, social support and health behaviours for women who are vulnerable to abuse.

4. Parenting programmes can reduce conduct disorders and later anti-social behaviour, both of which are associated with future partner violence, and also prevent maltreatment, which is strongly associated with the later experience or perpetration of IPV or sexual violence.

4.1 Introduction

IPV, included in definitions of domestic violence or domestic abuse, includes acts of physical, emotional, psychological and financial abuse by those who are or have been intimate partners or family members, as well as sexual abuse and stalking (Home Office, 2013). A variety of terms are used to denote violence against a partner, including spouse abuse, battering and partner abuse. The UK definition of domestic violence also includes female genital mutilation (FGM) (see Chapter 5 of this report), forced marriage and other acts of 'honour-based' violence. The UK government also updated the definition in March 2013 to include (i) coercive control and (ii) violence in teenage intimate relationships.

A recent nationally representative study of children and young people in the UK found that 12% of under-11s, 17.5% of 11 to 17s and 23.7% of 18 to 24s had been exposed to domestic violence between adults in their homes during childhood (Radford et al., 2013). When looking at the last year only, the same study found that 3.2% of the under-11s and 2.5% of the 11 to 17s reported exposure to domestic violence in the past year. These figures do not include violence in adolescents' own intimate partner relationships (see below). Adult males accounted for 93.8% of cases where one parent had beaten up the other, showing that they were the main perpetrators. Although women can be violent in relationships with men, and violence is also found in same-sex partnerships, the overwhelming health burden of partner violence is borne by women (WHO, 2013).

The harm caused to children by exposure to domestic violence is widely recognised and can be lifelong. It has adverse effects on their healthy development, relationships, behaviour and emotional wellbeing (Stanley, 2011), and can include low self-esteem, depression, post-traumatic stress reactions, aggression, running away from home and risk-taking behaviour in adolescence (Bair-Merritt et al., 2006). Further, longitudinal research has shown that domestic violence is strongly associated with young people who begin offending at an early age and continue offending as adults (Moffitt et al., 2002). Such effects may result from being abused or neglected by the perpetrator, being harmed if they try to protect the victim, living in a climate of fear and controlling behaviour, and experiencing the fall-out of violence (such as homelessness and poor caregiver mental health).

Also covered in this chapter is teenage dating violence, which refers to physical, verbal, psychological / emotional and sexual abuse in the context of romantic adolescent relationships (Offenhauer and Buchalter, 2011). The prevalence rates of teenage dating violence vary depending on the population and measure but research from several countries shows that it affects a significant proportion of adolescents (De Koker et al., 2014). In the UK, a non-representative study including 8 schools from a mix of high and low deprivation areas found that 88% of 13 to 17 year-olds had experienced a dating relationship and, of these, an overwhelming number reported having experienced abuse (Barter et al., 2009). Emotional violence was the highest type reported (72% girls, 51% boys), with not insignificant rates for physical violence (25% girls, 18% boys) and sexual violence (31% girls and 16% boys). The various forms of violence in intimate dating relationships have a significant impact on young people, reflected in both externalising and internalising problems. Consequences include decreased mental and physical health and low academic achievement, and long-term effects such as depression and antisocial behaviour (Banyard and Cross, 2008).

This chapter focuses on the 10 systematic reviews and 5 randomised controlled trials (RCTs) that were identified, first drawing out the evidence of effectiveness and then highlighting key messages for implementation. The majority of the studies are concerned with preventing psychological and physical violence in teenage dating

relationships ('dating violence'), which can be viewed as a form of primary prevention of IPV, although interventions seeking to prevent IPV more widely are also reported. The chapter does not address interventions concerned with identifying IPV (for a summary of systematic reviews on this subject see Chapter 5 of Axford et al. 2015a).

4.2 Systematic reviews

Whitaker et al. (2006) reviewed interventions targeting the primary prevention of perpetration behaviour related to IPV (interventions designed to prevent victimisation were excluded). The study included 11 interventions, all of which were adolescent dating violence prevention programmes. Most were universal (one community-based programme targeted young people at risk of developing abusive relationships). Programmes were aimed at young people aged 10 to 18 years, with a particular focus on those aged 14 to 16 years (the mean age in the 9 studies that reported age was 14.6 years). The majority (9) of the interventions were delivered in school. Intervention duration varied, ranging from 2 to 36 hours in the 6 studies that reported on this, although the majority were brief, with only 2 lasting more than 5 hours. Interventions were delivered by teachers (4), or community-based professionals such as social workers, advocates, police officers and abuse survivors (5), or both (2). The review does not indicate the countries where studies took place, and the quality of included studies was regarded as generally poor.

Of the 11 evaluations included in the review, 6 were RCTs (one of which was a head-to-head trial with no control group), 3 were quasi-RCTs, and 2 used a pre-post design. A narrative summary examined the impact of the interventions on 3 types of outcome, namely participants' knowledge (typically of information targeted by the intervention), attitudes (around justification, norms, date rape and sex roles) and behaviour (IPV perpetration). As such, the study had a fairly broad focus compared with a review such as the one by De Koker et al. (2014), described later in this chapter, which focused solely on behaviour change. Overall, at least one positive intervention effect (that is, for one of the 3 outcome areas) was reported in 9 of the 11 studies reviewed by Whitaker et al. (2006). Specifically, there were statistically significant positive effects for attitudes (5/9 studies), knowledge (5/6) and behaviour (2/4). The 2 interventions that had a positive impact on behaviour were the most comprehensive interventions, using both individual-level curricula and other community-based interventions.

The authors concluded that while it was premature to draw conclusions about the overall efficacy of dating violence interventions, such programmes were promising. They noted that efforts to prevent the perpetration of partner violence consisted almost exclusively of universal, school-based, dating violence prevention programmes that target individual-level factors and are rooted in a combination of feminist and social learning (or cognitive behavioural) theory. Accordingly, they recommended: expanding the theoretical basis for interventions; developing targeted interventions that directly

address risk factors believed to lead to partner violence (such as being abused or neglected, substance use, witnessing partner violence at home); tailoring interventions to make them culturally sensitive; and identifying new (non-school) settings to reach young people not engaged in school. The authors also called for research to understand the change mechanisms involved in such programmes.

Whitaker et al. (2013) reviewed interventions to prevent IPV victimisation and/or perpetration. In line with the study's focus on primary prevention, programmes were mainly universal, for middle or high school teenagers (US school grades 6 to 12, approximately 11 to 18 years old), generally curriculum-based and mostly delivered in group settings in schools (other settings included college campuses, juvenile court, youth centres or other community locations). Generally, interventions focused on physical and psychological partner violence, though some targeted sexual violence as well. Programme content varied across programmes but elements included changes in social norms regarding partner violence, the legal aspects of partner violence and the development of positive relationship skills (such as conflict resolution and managing emotions and anger when dealing with others). Not all studies described programme duration and intensity but for those that did there was a considerable range – 3-21 sessions (mean 8.3) over a total of 3 to 36 hours (mean 11). Little information was given on intervention providers.

The review included 19 studies (15 RCTs and 4 quasi-experimental design studies), all of which except one (Kenya) were conducted in the US. Although the review focused on measures of IPV behaviours, attitudes, beliefs and knowledge and other variables relevant to IPV, the primary focus in the description of findings was IPV behaviour.[28] The narrative synthesis concentrated on the 9 studies assessed by the authors as being methodologically rigorous (meaning that they had randomised designs, measures of IPV behaviour, sufficient-sized samples, acceptable retention rates and follow-up at least 6 months post-intervention). Of these, 7 demonstrated a positive impact on IPV behaviour (reducing perpetration, victimisation or both) with no negative effects. In 2 of these studies the programmes were school-based (in one case the positive effect was for boys only; in the other, which found unqualified positive effects on IPV behaviour, there were community activities as well). The 2 other rigorous school-based studies did not find positive effects on behaviour. The remaining 5 interventions with a positive effect on behaviour (marginally significant at p=0.06 in one case) were non-school based and included 2 community-based interventions (one with young people whose parents were involved in the child protection system), 2 couples-based interventions (a pre-marriage preparation course and a programme for pregnant teenagers and their

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[28] The authors argued that while knowledge and attitudes about IPV are modestly associated with IPV behaviour, and common targets of prevention efforts, "the relevance of these variables to prevention of IPV at the individual level has not been clearly established" (p.179).

partners respectively) and one family-based approach (working with parents to promote dating violence prevention with their teenage children).

The review authors concluded that although findings for several programmes "provide optimism with regard to dating violence prevention" (p.190), the results were mixed, even though interventions often share similar constructs. Accordingly, they advised that "there is much more work to do to understand which programs are effective, why they are effective, and how to disseminate them broadly without compromising effectiveness" (p.190). None of the studies were replicated, meaning that each intervention was supported by a single study only, and mediational models are needed to test the effects on behaviour of changing IPV-specific knowledge or attitudes (for instance, regarding gender roles) or more general social, emotional and behavioural skills.

De Koker et al. (2014) reviewed primary and/or secondary prevention interventions that seek to prevent and/or reduce IPV (physical, sexual and psychological) perpetration and victimisation among adolescents (in order for studies to be eligible the age of the majority of the sample had to be aged 11 to 19 years). Studies that focused on a specific sub-population, such as young drug users or adolescents in juvenile institutions, were excluded. As indicated earlier in this chapter, this review was mainly concerned with measuring behaviour change. The review included studies of 6 interventions, all operating at a universal level and recruiting participants from schools. Five of the 6 interventions involved a curriculum consisting of sessions on, for example, personal safety, sexuality and related health problem-solving or communication skills. Collectively, studies covered the age range 11 to 26 years. Interventions were delivered by a range of providers, including teachers, attorneys, school staff, sports coaches or trained facilitators. The length and intensity of interventions also varied considerably, with programmes lasting 1 to 5 months and involving 3 to 50 hours of delivery. Five interventions were school-based, with 2 of these including a community component. One intervention was community-based and delivered on school premises but outside of school hours.

Each of the 6 interventions was evaluated in a cluster RCT, with results summarised by the review authors in narrative form. Three demonstrated statistically significant positive effects on IPV outcomes (perpetration and victimisation) for both sexes: Safe Dates (physical, sexual, psychological), Fourth R (physical), and Shifting Boundaries (types of IPV not specified). According to the review authors, the other 3 (Ending Violence, Stepping Stones and Coaching Boys) had no impact on any of the IPV outcomes measured. De Koker et al. (2014) stated that findings must be treated with caution owing to limitations in the quality of the individual studies but concluded that interventions targeting the perpetration and victimisation of IPV among adolescents can be effective, and that they are more likely to be effective if they are based in multiple settings and focus on key people in the adolescent's environment. They argued that future trials should assess the perpetration and victimisation of IPV among male and

female adolescents with and without prior experiences with IPV, taking gender differences into account.

Petering et al. (2014) reviewed interventions designed to prevent and reduce youth IPV victimisation and perpetration. They included programmes for the general youth population and, because the review sought to identify suitable programmes for homeless youth, at-risk young people (including those with previous experience of violence or histories of maltreatment). The interventions were predominantly for young people aged 12 to 18 (mostly 14 to 16) years and most sought to change outcomes in multiple domains, including knowledge, attitudes, perpetration and victimisation behaviours, conflict resolution skills and communication patterns. The universal interventions mostly took place in schools and were delivered by "health teachers" (p.122) in health classes. They ranged from a single 40-minute session to a 21-lesson curriculum of approximately 28 total hours. The targeted interventions were more varied: delivery settings included specialist school settings for high-risk youth, public middle schools and community agencies. They lasted 3 to 24 sessions, with most including short weekly sessions (45 to 90 minutes).

Thirteen studies were included, of which 7 were for the general youth population (6 RCTs and one non-experimental pre/post-test design) and 6 for homeless young people (2 RCTs and 4 non-experimental pre/post-test designs). All took place in the US or Canada. Nine primary outcomes were measured across all studies: attitudes toward IPV and gender norms; conflict resolution skills; healthy relationship skills; help-seeking behaviours; knowledge of the criminal justice system related to IPV; bystander efficacy; emotional distress; increased knowledge and awareness of IPV; and victimisation and perpetration across various domains (physical, sexual, psychological and emotional). A narrative synthesis showed that while most programmes at a general youth population level had positive results for some outcomes, measures were inconsistent and, in the few studies that conducted a 6-month follow-up, many positive effects identified at post-test had dissipated over time. Many programmes for at-risk young people showed significant change in the desired direction but the majority of the studies were non-experimental. The authors concluded that there are very few prevention programmes that are implemented widely and which have shown strong positive results directly related to IPV victimisation and perpetration, and that targeted programmes for at-risk young people are at the developmental stage. They recommended that future studies apply more consistent measures of IPV victimisation and perpetration and include long-term follow-ups, and that booster sessions be incorporated in an attempt to enhance long-term effectiveness.

De La Rue et al. (2014) reviewed school-based interventions designed to prevent and/or reduce teenage dating violence (interventions could also seek to change other outcomes). They included interventions that were delivered to pupils aged 11 to 18 years in school settings. Interventions were mostly delivered by teachers, although

some were delivered by community professionals or research staff/graduate students. The majority ranged in duration from one day to 15 weeks, and sessions, where reported, lasted 40 to 80 minutes.

The review included 23 studies (10 RCTs, 12 quasi-experimental design studies (QEDs) and one quasi-RCT), all conducted in the US or Canada. Meta-analyses found statistically significant post-test effects favouring the intervention for knowledge, attitudes (less accepting of violence in relationships), rape myths[29] acceptance (less accepting), victimisation and the Conflict Tactics Scale (CTS)[30] (increased awareness of appropriate approaches to conflict resolution). There was no post-test effect on perpetration. Follow-up effects were found for knowledge, attitudes and perpetration but not for victimisation or the CTS (analysis was not conducted for rape myth acceptance as only one study reported this at follow-up). The authors concluded that the results are tentatively encouraging, especially with regard to knowledge and attitudes, but that prevention programmes do not impact dating violence perpetration or victimisation "to a great extent" (p.6). They advised that future research should focus on developing and testing programmes that incorporate skill-building components. Other research recommendations included: developing or adopting more nuanced measures of dating violence perpetration and victimisation given their low prevalence in adolescent relationships; examining the role of the bystander and how prevention programmes may shift the peer culture to be less tolerant of dating violence; and working out the best developmental timing for interventions and the measurement of impact.

Fellmeth et al. (2013) reviewed universal and targeted educational and skills-based programmes aimed at preventing relationship and dating violence in adolescents and/or young adults. Interventions were delivered in university, high school and the community (target age 12 to 25 years), by established teaching staff in the respective institutions, members of a third-party organisation specialising in the delivery of such interventions, or study authors. The majority of interventions were universal, with only 5 of the included studies evaluating interventions that target high-risk groups (such as individuals with a history of maltreatment). Interventions ranged in length from a single 50-minute session to 18 sessions delivered over 4 months, but the most common format was a single session lasting 50 to 90 minutes.

The review included 38 studies (18 RCTs, 18 cluster-RCTs and 2 quasi-RCTs), all of which except one (Republic of Korea) were conducted in the US. Meta-analyses were conducted on 6 outcomes. Unfortunately, for the purposes of the present review, results

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[29] Rape myths have been defined as widely and persistently held but generally false attitudes and beliefs that serve to deny and justify male sexual aggression against women (such as "husbands cannot rape their wives") (see Lonsway and Fitzgerald, 1994).

[30] The CTS is a widely-used measure of the behaviours used by respondents and their partners to resolve conflict in their relationship (including negotiation, psychological aggression, physical assault, sexual coercion and injury) (see Straus et al., 1996).

were not disaggregated to adolescents only. Although there was a statistically significant positive effect on knowledge relating to dating and relationships violence, there was substantial heterogeneity, and no effect was found for the other 5 outcomes, namely episodes of relationship violence events (categorical data), the occurrence of relationship violence (continuous data), behaviour towards relationship violence and skills related to relationship violence. The authors concluded that their review found no evidence of an effect of interventions on the outcomes reported. They argued that further research needs to: measure the effects of interventions on the incidence of violence (rather than focusing solely on attitudes and knowledge); explore the relationship between attitude and knowledge on the one hand and skills, behaviour and episodes of violence on the other; have longer follow-up periods; and use standardised and validated measurement instruments to maximise the comparability of results.

Stanley et al. (2015a) applied a mixed methods approach to study school-based interventions addressing domestic abuse (or dating violence) in young people aged under 18 years in the general population, with a focus on relevance for the UK.[31] As part of this, they undertook a systematic review which included 28 papers reporting quantitative data, of which 13 reported data from 9 'controlled' studies relating to 9 interventions and 15 papers reported on 14 'cohort and case-control' studies. The studies were conducted in North America with the exception of 2 in the UK and one in India. Programmes targeted young people aged 11 to 18[32] and were universal, with the majority taking place in schools. They ranged in length from 3 35-minute sessions to 21 classroom sessions totalling 28 hours (the majority involved 10 to 15 sessions). The interventions used a selection of taught sessions, role-play, discussion groups, audio-visual material and participative theatre as the vehicle for delivery, with some including counselling for those affected by the intervention. Delivery was mainly by teachers and school sports coaches but in some cases external volunteers and professionals were involved. The studies included in the review measured knowledge, attitudes/beliefs, reported behaviour (such as communication skills and help seeking) and the incidence of victimisation and perpetration.

The narrative review found that where statistically significant findings were reported, the effect sizes were generally low or moderate. Larger effect sizes were seen on measures of knowledge and attitudes than on behavioural change, although the differences in these tended to decrease over time. An increase in help-seeking was evident across some studies. Two studies identified negative programme effects, namely increases in sexual harassment and the perpetration of violence and negative changes in attitude scores (these were not explained). Regarding perpetration and victimisation, the only relatively large and statistically significant finding in a single well-designed study

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[31] This study was also reported in shorter form in Stanley et al. (2015b).
[32] The review pointed out that although preventive interventions for children aged under 11 years are widely delivered in the UK, there is no rigorous evidence on their effectiveness with this age group.

concerned a reduction in the perpetration of physical dating violence by boys (not girls). Gender analysis across the studies revealed mixed effects with no obvious pattern, and no difference in response in 8 of 21 papers.

Stanley et al. (2015a) supplemented their review of quantitative data with analyses of qualitative data (6 papers, 3 of which also reported quantitative data) and grey literature (18 evaluations of UK programmes). These showed that young people who received the interventions generally found them to be enjoyable and valuable. The grey literature review largely echoed the findings of the systematic review in terms of finding more evidence for increased knowledge and attitude change than for behavioural change.

The authors' overall conclusions focused less on evidence of effectiveness than on (i) implications of the relative lack of effectiveness observed in relation to behaviour and (ii) broader findings of the review regarding implementation. These covered issues such as target group, programme duration and cultural and organisational context (see sections 4.4 to 4.6 below). Regarding future research, owing to concerns about the cross-cultural transferability of programmes developed in North America the authors advised concentrating on developing and rigorously testing interventions that are widely delivered in the UK, including estimating costs and cost-effectiveness.

Until now, this chapter has focused primarily on reviews of dating violence interventions. The following 3 reviews look at a a wider set of interventions.

The first is a summary of interventions to identify, prevent, reduce and respond to domestic violence between family members or between people who are (or have been) intimate partners, with a focus on studies from high-income countries (British Columbia Centre of Excellence for Women's Health, 2013). The review informed the subsequent NICE (2014) guidance on domestic violence. It focused on interventions that aim to prevent and respond to domestic violence respectively, but, in accordance with the focus of the present review, the results reported here are those that concern preventing domestic violence (a combination of universal and selective prevention).[33] Four types of intervention were included in this category, namely: preventive interventions for young people (such as healthy relationships education delivered in school by teachers [effectively dating violence prevention]); media campaigns (for example adverts or articles delivered via radio, TV or online, also posters and leaflets in service settings); prevention interventions in health care settings (including leaflets in emergency room

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[33] As such, findings in the British Columbia Centre of Excellence for Women's Health (2013) review that are concerned with the following are not reported here: (1) interventions or approaches used in health and social care settings *for responding to violence*, including (a) advocacy, skill-building, counselling and therapy for victims, (b) individual or group interventions for abusers, and (c) couple sinterventions; (2) interventions or approaches used in health and social care settings *for children exposed to domestic violence*, including (a) counselling/therapy, (b) crisis- or outreach-orientated services, (c) services focused on parenting and/or the parent-child relationship, and (d) multicomponent interventions that include 2 or more of the preceding 3 types of intervention together with approaches such as advocacy, social support, and making links between agencies; and (3) *partnership approaches*, such as inter-agency collaborations for handling cases of domestic violence.

[Accident and Emergency] washrooms); and prevention programmes implemented in community settings (notably home visiting for pregnant teenagers, or clinic-based groups for adolescent parents). Collectively, these interventions targeted adults and children. A total of 148 studies were identified for this area, of which 14 (2 from Scotland and 12 from the US; 3 RCTs, one non-RCT, 5 pre-post, 3 cross-sectional and 2 qualitative) were included and reported on, alongside 2 systematic reviews[34] on IPV prevention (effectively reviews of dating violence prevention programmes). Together, they measured the following outcomes: attitudes, knowledge, exposure to educational materials and, to a lesser degree, behaviour.

A narrative summary of the 2 systematic reviews examined in the British Columbia Centre of Excellence for Women's Health (2013) report stated that evidence for the efficacy of adolescent dating violence prevention programmes is inconclusive. Although early results demonstrate positive changes in attitudes, there is a need for more methodologically robust studies with measures of behaviour, longer follow-up periods and attention to validity and fidelity. A narrative analysis of the 14 primary studies yielded the following main results. First, there was modest evidence from 5 studies that prevention programmes that target young people at risk for partner violence may improve participants' knowledge of IPV, interpersonal skills and attitudes towards violence and gender roles. Some studies conducted with young people at high risk for abuse also reported modest improvements in abuse/violence outcomes. The evidence for primary prevention programmes for young people was judged to be weak. Second, regarding media campaigns addressing IPV, there was inconsistent evidence from 4 studies that such interventions are associated with improvements in recall, hypothetical bystander actions, awareness of available resources, calls to hotlines and knowledge and perceptions of domestic violence. The review authors suggested that media campaigns may be useful in raising awareness of domestic violence and services, particularly in rural contexts, but pointed out that the limited reach of campaigns can be a potential barrier to their effectiveness. Third, the 2 studies of prevention interventions implemented in health care settings (both emergency departments) provided weak evidence of an association with exposure (reports of noticing, reading or retaining of materials), or changes in knowledge and attitudes related to domestic violence. Neither of these studies measured actual behaviour. Fourth, there was weak evidence from 2 studies that prevention programmes delivered in community settings are associated with improved knowledge and skills, attitudinal and psychological outcomes, social support and health behaviours for women who are vulnerable to abuse. The review authors recommended that interventions designed in the future are tailored, are developed and implemented in the community, engage high-risk groups and address

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[34] One of the 2 reviews is included in the present review (see Whitaker et al., 2006, covered earlier in this chapter). The other review (Murray and Graybeal, 2007) is not included in the present review because it was concerned with methodological quality rather than intervention effectiveness.

multiple levels of prevention. In terms of research, they recommended longer follow-up to see whether the changes observed in attitudes translate into changes in behaviour.

The second review of a wider set of IPV interventions (Lundgren and Amin, 2015) looked at interventions to prevent IPV and sexual violence.[35] The populations targeted were parents, school children, university students and children and adolescents who had experienced child maltreatment or who were exposed to parental IPV. The review focused on 10 to 26 year-olds (originally it targeted interventions for 10 to 19 year-olds but found too few studies and so expanded the age range). The interventions included: parenting programmes (one-to-one or group settings) and targeted interventions for children and adolescents exposed to violence; school-based interventions (including interventions to prevent sexual assault among university students); community-based initiatives (group education, community mobilisation, social norm marketing, media campaigns, mentorship and the identification of safe spaces); and economic empowerment programmes (for women and girls only). There was little information in the review regarding intervention frequency and duration.

Of the 61 interventions identified, 14 were evaluated in comparison group studies (6 RCTs and 8 quasi-experimental designs). Most studies were from the US, despite a stated preference for low- and middle-income countries (only 17 were implemented in developing countries). The analysis focused on measures of attitudes (such as norms and bystander acceptance) and behaviour (notably experience and perpetration). A narrative summary of results distinguished between the different programme types. The evidence on parenting interventions and interventions for children and adolescents who are subjected to maltreatment was from high-income countries. Parenting programmes were found to reduce conduct disorders and later anti-social behaviour, both of which are associated with future partner violence, and to prevent maltreatment, which is strongly associated with later experience or perpetration of IPV or sexual violence. However, there is no long-term evidence showing that the children of parents who participate in such programmes are less likely to report IPV or sexual violence as grown-ups. One psychological intervention that targets children and adolescents who have experienced child maltreatment or parental IPV showed an impact on reductions in the perpetration and experience of dating violence in adolescence. Evidence on school-based dating violence prevention programmes was from North America. These were shown to be effective in preventing physical, sexual and emotional violence in adolescent dating relationships and may also help to prevent IPV and sexual violence among adults (they have only been evaluated in developed countries). Programmes targeting sexual assault were mostly for university students in high-income countries, and are therefore less relevant for the present review. Most evaluations of these showed a decreased acceptance of rape myths and an increased ability to correctly

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[35] It is important to note that the review was not confined to IPV because the sexual violence might be perpetrated by a stranger.

identify rape scenarios, but only the longer-term programmes reduced violence. Evidence on the other 2 categories of programme was mainly from developing countries, again making it less relevant here. Some community-based interventions reduced self-reported perpetration of violence and harassment, with increases in equitable gender norms, awareness of sexual violence and the likelihood of intervening in violent situations. There was limited evidence, however, that economic empowerment interventions prevent IPV or sexual violence among adolescents.

Overall, the authors concluded that school-based dating violence, parenting and community-based interventions are promising approaches to preventing IPV and sexual violence among adolescents and should be replicated and scaled up in different settings. However, they cautioned that the lack of rigorous evidence limits conclusions regarding the effectiveness of adolescent IPV and sexual violence prevention programmes and indicates a need for more robust evaluation. They also advocated studies with longer-term follow-up, in particular to determine whether building participants' social, economic and health assets – the strategy of the most promising programmes – has an effect on relationship violence. Other areas for intervention development and research include identifying the essential elements of successful programmes and developing interventions for young people aged under 15 and vulnerable groups (for example those not in school).

In the third review that covered a wider set of interventions, DeGue et al. (2014) examined programmes concerned with the primary prevention[36] of sexual violence perpetration.[37] The target group of the programmes in the studies they included was predominantly (60%) college [university] students and accordingly interventions were mainly set on college campuses, but – of greater relevance to the present review – there were also studies involving students in US school grades 5 to 9 (10 to 15 years), with settings including high school, middle school, elementary school, the community and other/mixed settings. The nature of the interventions varied considerably, covering interactive presentations, didactic lectures, film/media presentations, role-play, drama performances, written materials, poster campaigns and community activities/policy development. The majority were implemented by peer facilitators, advanced students or school/agency staff, and although programme duration and the number of sessions varied, most comprised one session only. The review does not state where studies took place.

The review included 140 studies (82 RCTs, 35 quasi-experimental evaluations and 23 pre-post studies) and provided a narrative summary of the results, focusing on 8 outcome types relating to sexual violence (such as behaviour, attitudes, knowledge,

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[36] The authors defined this in terms of universal interventions for the whole population and interventions targeted at those who may be at increased risk of sexual violence perpetration.
[37] The review was not confined to interpersonal violence i.e. it also covered sexual violence where the perpetrator might be a stranger.

bystanding behaviour and rape proclivity). A narrative analysis found that the majority of the studies had mixed effects. For the target age-group of the present review (5 to 19 years), only 2 interventions (both universal school-based dating violence prevention programmes) showed a positive effect on sexually violent behaviour established through rigorous evaluation: Safe Dates and Shifting Boundaries (building-level version[38]). The authors concluded that there is a lack of evidence-based interventions available to practitioners currently, and that this reflected the lack of rigorous evaluation in the area but may also stem from many existing programmes not following principles of effective prevention. Most of the sexual violence interventions in the literature, for example, were brief (often one session) psychoeducational programmes with college students focused on changing participants' knowledge and attitudes: "[N]one of these programs have provided consistent evidence of impact on sexual violence outcomes, and most have not shown evidence of lasting impact on the risk factors or related outcomes that were measured" (p.359). In terms of future research, the authors argued that more effective models might result from: attention to an expanded range of risk factors in intervention development; a broader set of behaviour change theories; and strategies that are multi-level (including individuals but also parents and peers) and that try to modify community and contextual supports for violence. The authors also advocated more research into the relative merits of culturally-specific approaches.

4.3 Primary studies

The search for relevant RCTs that were not included in the systematic reviews in this chapter yielded 5 studies. The interventions were all concerned with preventing dating violence among adolescents and delivered at least partially in a school context. The first one described below was universal but the others were targeted respectively at boys, girls, minority ethnic groups and children previously exposed to domestic violence.

School Health Center Healthy Adolescent Relationships Program (SHARP)

Miller et al. (2015) tested a brief universal relationship abuse education and counselling intervention designed to prevent or address adolescent relationship abuse (referred to by the authors as ARA: physical, sexual, or psychological abuse in the context of a past or present romantic relationship). SHARP is implemented by clinicians in school health centres (SHCs). In each clinical encounter, and regardless of the reason for the student's visit, the clinician initiates a discussion of healthy and unhealthy relationships and gives the student a brochure that they review together. This typically takes less than a minute but can lead to longer discussions if ARA is disclosed. School-wide

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[38] As opposed to the classroom-level (curriculum only) version. The building-level version sought to address policy and safety concerns in school, for example by ensuring a higher staff presence in unsafe 'hot spots' and displaying posters to increase awareness and reporting of dating violence and sexual harassment. In a 4-arm trial, positive effects were seen for the combined (classroom and building) and building-only versions (Taylor et al., 2013).

outreach events involving the school youth advisory board provide ARA information and encourage students to come to the school health centre.

A cluster RCT in Northern California, US, involved a final sample of 8 SHCs (7 clinic clusters: n=4 intervention, n=3 control). Patients were eligible if they were English- or Spanish-speaking, aged 14 to 19 years, seeking care for any reason and expecting to be available for follow-up. In terms of overall effect, at 3 months post-intervention, there were no statistically significant differences between the intervention and control conditions in relation to 4 outcomes: intentions to intervene; knowledge of ARA-related resources; recent use of ARA-related resources; and self-efficacy to use harm reduction strategies. However, there was a positive effect on a fifth outcome: compared with controls, at follow-up, intervention participants demonstrated greater increases in the recognition of sexual coercion. There were also sub-group effects for participants who had experienced ARA at baseline, including lower rates of recent experience of ARA compared with controls (including cyber dating abuse and physical or sexual abuse), and a greater likelihood of recognising abusive behaviours and being knowledgeable about ARA resources. The authors concluded that "[b]rief interventions such as SHARP embedded in clinical settings are a promising strategy for prevention and intervention" (p.81). However, they found that uptake by providers was a challenge and, given the limitations of the study, advocated a larger RCT with more clusters, more geographically diverse clinics and longer-term follow-up with assessment of health outcomes. In light of the lack of effect on intentions to intervene, they also advocated further research into how to encourage positive helping behaviours among high school students.

Coaching Boys Into Men (CBIM)

Miller et al. (2013) evaluated an intervention designed to reduce dating violence and targeted at male athletes aged 14 to 18 in high school. CBIM involves training athletic coaches to integrate violence prevention messages into coaching activities through brief, weekly, scripted discussions with athletes throughout the sports season (12 weeks). The intervention aims to increase the likelihood that young people will intervene when they see peers engaging in disrespectful and abusive behaviours.

The RCT took place in California, US, with 16 schools randomly allocated to the intervention or a control group. Data were collected after the intervention ended and 12 months after baseline. At 12 months there were no intervention effects for the primary outcomes of intentions to intervene, gender-equitable attitudes and recognition of abuse. In terms of secondary outcomes, statistically significant impacts were found in terms of reduced negative bystander behaviours (but not for positive bystander behaviours) and a lower prevalence of dating violence in the past 3 months among intervention participants relative to the control group. An earlier study (Miller et al., 2012) had identified positive impacts 3 months after the intervention started in terms of increases in intentions to intervene, positive bystander behaviour and the recognition of

abusive behaviours. The authors suggested that the failure to sustain these effects at 12 months might be because the follow-up data were collected at the start of the season when athletes had been on the team for a short period: in the absence of reinforcement from coaches and teammates they may have been less likely to intervene in other peer contexts. However, they also interpreted the positive effects at 12 months on negative bystander behaviours and abuse perpetration as showing that the earlier effects and hearing coaches' messages about stopping violence against girls during the sports seasons (that is, creating a social context that discourages dating violence perpetration) may prevent negative behaviours in the longer term. The authors concluded that the programme may buffer against the initiation of dating violence perpetration during a critical developmental period for young people. They also cautioned that while CBIM is one promising strategy to encourage conversations about masculinity and violence prevention, it is not a comprehensive violence prevention programme.

My Voice, My Choice (MVMC)

Rowe et al. (2015) conducted an RCT of a universal intervention designed to reduce male-to-female sexual victimisation by providing adolescent girls with training in and realistic practice with assertive resistance skills. The study took place in a large Southwestern city in the US, with a self-selecting sample drawn from an all-girls urban public high school (14 to 18 years) serving a predominantly minority population. The intervention was delivered to groups of 2 to 4 students at a time. It comprised a single 90-minute assertive resistance training session, which started with discussion and modelling of assertive resistance skills. Students were then exposed to 3 simulations via a virtual reality headset in which they had to respond to verbal sexual coercion from a male avatar (played by a male actor sitting next to them). After each simulation, the participant received constructive feedback from the female facilitator and fellow group members. Clinical psychology doctoral students with at least one year of clinical training facilitated the sessions.

Participants (mean age 15.63 years) were randomised to the intervention (n=47) or a control group (n=36). MVMC participants were less likely than the control group to report sexual victimisation at 3-month follow-up. There were no statistically significant effects for physical or psychological victimisation or psychological distress, although prior victimisation moderated the association between the intervention and psychological victimisation and psychological distress (i.e. it reduced risk for both of these but only among girls with relatively higher levels of prior victimisation). The authors concluded that the study supports prevention efforts that target risk-reduction by training girls to use assertive resistance skills. Future research needs to test the intervention with a larger sample and over a longer period, examine potential mediators of effects, and explore its efficacy with other age groups and males.

It's Your Game…Keep It Real (IYG)

Peskin et al. (2014) conducted an RCT of a universal school-based intervention designed to reduce dating violence behaviour among 12 to 14 year-olds from minority ethnic groups. The programme includes both classroom and computer-based activities in a 24-lesson curriculum over 2 school years. The computer-based activities are set within a virtual world environment and include interactive skills-training exercises, peer role model videos, quizzes, animations, fact sheets and 'real world' style adolescent serials. In addition, there are 6 parent-child homework activities and individualised journaling activities at each grade level to help students personalise information. It is implemented by trained facilitators.

The study took place in Texas, US, with 10 middle schools – all containing a high proportion of economically disadvantaged students – randomised to intervention (n=5) or control (n=5). It found a positive effect post-intervention on 3 of 4 dating violence outcomes. Compared with those in the intervention condition, control students had significantly higher odds of physical dating violence victimisation and emotional dating violence victimisation and perpetration. The odds of physical dating violence perpetration were not significantly different between the 2 groups. Programme effects also varied by gender and ethnicity. For example, only boys (not girls) in the control group had significantly higher odds of emotional dating violence perpetration, and among African Americans, only physical dating violence victimisation had significantly higher odds in the control compared with the intervention group. The authors concluded that while further study is warranted to determine if IYG should be widely disseminated to prevent dating violence, it is one of only a handful of school-based programmes that are effective in reducing adolescent dating violence behaviour. Regarding the lack of effect on physical violence perpetration, they suggested that future dating violence interventions for minority ethnic group young people should include: skills training in effective communication and conflict resolution; skills training for managing emotional responses, such as anger and stress, that could be triggers for physical dating violence perpetration; and role-modelling activities to help promote equal gender norms within dating relationships.

Moms and Teens for Safe Dates (MTSD)

Foshee et al. (2015) evaluated an intervention to prevent dating abuse among adolescents exposed to domestic violence. Moms and Teens for Safe Dates (MTSD) is for mothers who have previously experienced an abusive relationship and their adolescent children (12 to 16 year olds) who have been exposed to domestic violence. The intervention comprises a series of 6 booklets, the first of which is for the mother only and the remainder for the mother and adolescent. The booklets include dating abuse prevention information and interactive activities for the mothers to complete with their child.

The RCT involved 409 adolescents in families exposed to domestic violence and took place in several states in the US (the number allocated to intervention and control groups respectively was not specified). The results showed positive effects 6 months after the programme ended in terms of preventing the perpetration of psychological and cyber dating abuse and victimisation from psychological and physical abuse but in all cases these were only among adolescents with higher previous exposure to domestic violence. The effects were also small. There were no main or moderated effects on the perpetration of sexual or physical dating abuse or on victimisation from cyber or sexual dating abuse. The authors concluded that MTSD may be a viable programme to use for dating abuse prevention among this group of high-risk adolescents but that future studies should explore whether the effects, and especially the differential effects, can be replicated.

4.4 Implementation issues

It is generally acknowledged that, owing to their role in the development of social behaviour, schools provide an appropriate environment to target children and adolescents in the prevention of dating violence and subsequently other forms of relationship violence (Fellmeth et al., 2013). That said, schools' readiness to implement preventive interventions is an important consideration (Stanley et al., 2015a), and an exclusive focus on schools is likely to be insufficient. For example, children outside of mainstream school may be excluded from such interventions, which is particularly problematic as they may be the most vulnerable (Stanley et al., 2015a). De Koker et al. (2014) reviewed interventions that sought to prevent and/or reduce IPV among adolescents and found that effective interventions were based in multiple settings (school and community) and focused on key adults in the adolescents' environment (notably teachers, parents and community members). Effective interventions also addressed relationship skills. Interventions that consisted solely of changes to the curriculum were not effective. Similarly, Whitaker et al. (2013) welcomed the expanding scope of settings – that is, beyond schools – for IPV prevention in recent years, partly because alternative settings have proven useful for addressing other adolescent risk behaviours (conduct problems, substance abuse, risky sex and so on) but also because it acknowledges the influence of parents on teenage behaviour. They argued that there was greater scope to explore the effectiveness of intervening in other settings, notably through various media.

Stanley et al. (2015a) noted that some school-based dating violence prevention programmes have a high degree of cultural specificity, meaning that "dynamic sensitivity to local context" (p.76) may be more likely to trigger mechanisms of change than strict fidelity to the original programme design. They further suggested that because there is evidence for a lack of cross-cultural programme transferability, there should be a focus on further developing and testing interventions that are already delivered widely in the

UK. This might include improving the readiness of schools to deliver programmes, which would entail providing training and information on current evidence for the school's leadership, governors and parents.

Intervention duration was also explored in some studies, with some apparently conflicting results. De Koker et al. (2014) found that shorter interventions were not effective, while Lundgren and Amin (2015), who reviewed programmes to prevent IPV and sexual violence among adolescents and young adults, concluded that programmes with longer-term investments and repeated exposure to ideas delivered in different settings over time have better results than single awareness-raising or discussion sessions. De Gue et al. (2014) concluded that, in general, sexual violence prevention interventions with consistently positive effects were about 2 to 3 times longer on average than those with null, negative or mixed effects. Similarly, Petering et al. (2014), who examined prevention programmes for IPV in the general and at-risk youth populations respectively, found that the strongest programmes were the longest and most intensive. They suggested that programmes should be implemented over a longer period as this is more likely to allow time for behavioural change. Stanley et al., (2015a) found that school-based interventions appeared to be more effective if they were longer and delivered by appropriately trained staff. However, De La Rue et al. (2014) found no significant moderating effects of intervention duration in their review of school-based dating violence prevention programmes, and Fellmeth et al. (2013), who reviewed universal and targeted dating violence prevention programmes, found no significant subgroup differences in terms of the duration or number of sessions received.

The target group of interventions may also have a bearing on effectiveness, although again the evidence is somewhat conflicting. De La Rue et al. (2014) could not determine how programme type, one element of which was universal (others being psycho-educational, individual or classroom level), contributed to differential efficacy in preventing perpetration and victimisation in dating relationships. By contrast, Fellmeth et al. (2013) found significant subgroup differences between interventions aimed at general audiences and those aimed at high-risk audiences in the episodes of relationship violence experience and attitudes towards relationship violence: in both cases the difference favoured the high-risk group. One aspect of target group is age, and Petering et al. (2014) advocated starting at a younger (pre-adolescent) age to increase participants' knowledge and awareness of IPV as well as their knowledge of healthy relationship patterns. Another aspect of target group is gender, and one review concluded that dating violence prevention programmes seem to be more effective when implemented separately with males (Lundgren and Amin, 2015).

Whitaker et al. (2006) noted that the 2 dating violence prevention programmes with positive effects on behaviour included individual-level curricula but also community-based actions (that is, they were more comprehensive). This point is echoed by Lundgren and Amin (2015), who stated that, with regard to interventions to prevent IPV

and sexual violence, repeated exposure to ideas in different settings over time is a feature of the more successful interventions. They further suggested that programme-level strategies to prevent IPV are only part of the approach needed to address the problem. Policy-level efforts to promote greater gender equality are also needed, as are initiatives involving leaders and other members of the community to challenge social norms that condone gender-based violence (for example social marketing or mass media / 'edutainment' efforts aimed at adolescents).

4.5 Workforce skills and training

It was generally acknowledged in the studies reviewed for this chapter that having well-trained staff is important, and that effective programmes tend to have staff or implementers who are stable, committed, competent and able to connect effectively with participants (Mihalic et al., 2004, cited in DeGue et al., 2014). Yet in the review by DeGue et al. (2014), only about one-quarter of the interventions were implemented by professionals with expertise related to sexual violence prevention and extensive knowledge of the programme model (that is, programme developers and sexual violence prevention practitioners). The majority were instead delivered by peer facilitators, advanced students or school/agency staff lacking subject expertise. Stanley et al., (2015a) advocated further training for teachers, provided by those with specialist knowledge and skills in domestic abuse, and suggested that this could begin pre-qualification and be followed up once the teacher has qualified. They also argued for school leaders and governors to be trained. Fellmeth et al. (2013) found that most studies provided training (to varying degrees) for the people delivering the interventions. Some provided practitioners with a script or detailed guidance to follow to minimise the potential for deviation from the design.

That said, there was little research into the impact on intervention effectiveness of who delivered programmes or the nature of their skills and training. The issue was tested in one review of dating violence prevention programmes, which found that there was no significant moderating effect relating to who delivered the programme (teacher vs. other) (De La Rue et al., 2014). Clearly more research on this issue is needed. For example, DeGue et al. (2014) contended that the sexual violence prevention field would benefit from more extensive descriptions of programme staff and training and implementation research to determine characteristics of programme staff that may enhance programme effects. A good example of why this is important is the recommendation by Petering et al. (2014) that youth peers should be used as leaders because a peer-leader model was beneficial in HIV-prevention programmes; while this may be true, it needs testing for IPV programmes.

4.6 Identifying children and young people in need of additional support

DeGue et al. (2014) advocated targeting younger populations and changing supportive attitudes in the community towards violence. They called for a move away from low-dose educational programming in adulthood and toward developing and rigorously evaluating more comprehensive, multi-level strategies (that is, involving individuals, parents, and peers) that target younger populations and seek to modify community and contextual supports for violence. While acknowledging that men and women attending university are at a particularly high risk for sexual violence perpetration and victimisation, making this a key population for intervention, they pointed out that many university-age males have already perpetrated sexual violence before arriving on campus, or will shortly thereafter, and therefore primary prevention efforts may best be targeted at younger populations.

Wider culture has a major influence on these outcomes, a point highlighted by Stanley et al. (2015a) who suggested that the influence of the values and attitudes of the peer group means that programme material should be targeted towards whole populations of children and young people. Whitaker et al. (2013) also suggested that primary prevention should target everyone but identified groups that are at high-risk for IPV: young, pregnant teenagers; adjudicated youth who have committed violent offences; and teenagers whose parents were involved in the child protection system. They also advised that selective prevention efforts should take into account the fact that many of the individuals receiving the intervention will already have perpetrated or experienced IPV.

As indicated above, Stanley et al. (2015a) noted that shifting social norms in the peer group emerged as a crucial mechanism of change, and suggested that this speaks to continuing to deliver interventions to whole populations of young people. However, school-based interventions may miss young people most at risk of experiencing domestic abuse, as they may not attend school. On this basis, the authors recommended that school-based programmes should build close links with support services that can respond to disclosures of domestic abuse and offer additional interventions to children at high risk. They also recommended that programmes be developed for LGBT, disabled and minority ethnic group young people. Finally, the authors argued that interventions with younger children (under 10 years) might yield better effects given the relative lack of effects with older children, whose values, attitudes and behaviour are established via family, the community and early socialisation by the age of 10.

4.7 Summary

The majority of the interventions covered in this chapter are school-based programmes for adolescents, with a curriculum delivered by teachers, researchers or others (for example sports coaches) in group settings over several sessions. They address domestic violence in adolescent relationships (or 'dating violence') and may be considered a form of primary prevention of IPV. Most of them operate at a universal level, which made them well placed to harness the important change mechanism of shifting the peer norm in social groups, although a small number are targeted by demographic characteristics (such as gender) or risk (such as prior exposure to IPV). Nine systematic reviews looked at such programmes (8 exclusively), as did 4 additional RCTs. Overall they are promising. There is reasonably strong evidence, mainly from North America, of their positive effects in terms of improved attitudes and increased knowledge around dating violence, and, although arguably not as strong, there is also evidence of their impact in terms of behavioural outcomes (notably victimisation/perpetration). Effects can fade, however, and results are often mixed depending on the type of violence being measured – effects on some types but not others – and the severity of the problem before the intervention. There would also appear to be some gender differences – for example, a reduction in perpetration by boys but not by girls.

Not all of the programmes in these reviews were school-based. There is evidence that those implemented in the community, which tend to be targeted (notably for children of parents involved in the child protection system, or for teenage parents and their partners, or for parents of children exposed to previous domestic violence) are effective in reducing victimisation and/or perpetration, albeit with some of the earlier caveats about there being variation in impact. There is also some evidence that the school-based interventions are more effective if supplemented by other activities (that is, more comprehensive approaches involving multiple settings and targeting key people in young people's environment).

Common messages regarding the implementation and future development of dating violence interventions included:

- focusing on a broader range of behaviour change theories and risk factors (notably those believed to lead to partner violence, such as substance abuse, being abuse or neglected and witnessing domestic violence at home)
- implementing interventions in multiple settings (school and community), not least to reach those young people who are not engaged in school (and therefore arguably the most vulnerable)
- focusing on influencing key people in the adolescent's environment (notably parents, teachers and community members) as well as the adolescents themselves

The importance of participants being trained in effective communication and conflict resolution skills was stressed, as was the promotion of equal gender roles to address the potential causes of dating violence. It was also advised that school-based programmes should build links with support services that can respond to disclosures and support children at high risk. The length of interventions considered in reviews varied considerably, and there were conflicting messages about whether duration is associated with effectiveness: on balance it arguably favours longer and more intensive interventions. If teachers are to deliver interventions, they arguably need more and better training provided by those with specialist knowledge and skills in domestic abuse, as do others in the school (notably school leaders and governors). Schools need to be properly ready to implement interventions, which necessitates training for school leaders and parents, and some degree of intervention adaptation for the local cultural context is likely to be required (particularly when importing from other countries, notably the US). Although young people at high risk of IPV can be identified, and some degree of targeting is arguably merited, the influence of peer group values and attitudes on dating violence provides a strong justification for the continued use of universal – often school-based – approaches. There is also a case for working with younger children, in particular those aged under 10 years (before certain attitudes and behaviours become embedded). Lastly, programme-level responses need to be complemented by policies that promote greater gender equality and by community action to challenge norms that condone gender-based violence.

In terms of future research on dating violence prevention, several studies advocated longer follow-up time to test if initial gains are lost and the more consistent use of standardised measures to enable the synthesis of findings. The development of more nuanced measures of dating violence was also advocated (because of its relatively low prevalence in adolescent relationships), as was an exploration of the influence of peer culture. In addition, it was suggested that the more explicit description and testing of anticipated programme change mechanisms would help with understanding why programmes are – or are not – effective, particularly since at face value many share similar elements. This is likely to require using mediation models to test the effects on victimisation and perpetration of changing participants' knowledge, attitudes and bystander involvement.[39] More replication studies are needed, because many interventions have been tested in a single study only. Other recommendations include the development and rigorous testing of programmes delivered widely in the UK, owing to concerns about the cross-cultural transferability of imported interventions (most of the dating violence interventions reviewed were evaluated in North America) and the

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[39] For example, a literature review of bystander interventions to prevent dating abuse among adolescents and young adults (Storer et al., 2016) concluded that such interventions "show strong promise for increasing individuals' confidence in acting as positive bystanders and their willingness to intervene in situations that could lead to sexual or dating violence" (p.267) but that further research is needed to explore "the translation of attitudes and cognitive changes into sustained changes in intervening behavior among all program participants, especially those most resistant to change" (p.267). (The review included 15 empirical evaluations of 9 programmes, with the majority (n=7) directed to young adults on university campuses.)

evaluation of media-based approaches and interventions for younger (pre-adolescent) children. Since public health initiatives are complex and wide-reaching, evaluation should also examine the costs and benefits of interventions to all sectors of society.

Three reviews covered a wider set of interventions to prevent IPV. The first of these found that: media campaigns may be useful in raising awareness of IPV and relevant services, although their limited reach may be a potential barrier to their effectiveness; there is weak evidence from a small number of studies that information leaflets in healthcare settings can change knowledge and attitudes regarding IPV; and there is weak evidence that community-based interventions (home visiting for pregnant teenagers, and a clinic-based group for adolescent parents) improve various outcomes, including knowledge, skills, social support and health behaviours for women who are vulnerable to abuse (British Columbia Centre of Excellence for Women's Health, 2013).

The second review with a wider focus found that parenting programmes can reduce conduct disorders and later anti-social behaviour, both of which are associated with future partner violence, and also prevent maltreatment, which is strongly associated with the later experience or perpetration of IPV or sexual violence (Lundgren and Amin, 2015). It called for longer-term follow-up, identifying the successful components of effective interventions and developing interventions for young people aged under 15 years and/or not engaged in school.

The third review in this category focused on the primary prevention of sexual violence perpetration (DeGue et al., 2014); for the age group covered by the present study it identified 2 (mainly school-based) programmes that were effective in this respect. It reiterated the importance of delivering multi-level interventions (involving parents and peers, and addressing community and contextual factors), addressing a wider range of risk factors and behaviour change theories, and tailoring interventions so that they are culturally-specific.

Implications for policy and practice

1. School-based (mostly universal) dating violence prevention programmes for adolescents deserve to be implemented but also tested more widely in the UK given (i) the reasonably strong evidence that they can improve participants' knowledge, attitudes and, albeit to a lesser extent, behaviour, (ii) the fact that they are well placed to change the peer norm in social groups, and (iii) the need to develop a local evidence base (most of the evidence is from North America). Community-based (usually targeted) dating violence prevention programmes also warrant wider implementation given evidence of their effectiveness in reducing victimisation and/or perpetration (albeit with some variation and again with the requirement for further testing).

2. Dating violence prevention programmes are considered likely to be most effective, especially at reducing actual victimisation and perpetration, if they: focus on a broader range of risk factors and behaviour change theories; involve repeated exposure in multiple settings (school and community); train participants in emotional intelligence and effective communication and conflict resolution skills; focus on influencing key people in the adolescent's environment (as well as the adolescents themselves); promote equal gender roles; build links with support services that can respond to disclosures and support high-risk children; provide teachers (and other school staff) with more and better training from people with specialist knowledge and skills in domestic abuse; are sensitive to the local cultural context; and, in the case of school-based interventions, are delivered in schools that are properly ready for implementation. There is also a case for intervening with pre-adolescents. These programme-level responses need to be complemented by policies that promote greater gender equality and by community action to challenge norms that condone gender-based violence.

3. The development of adolescent dating violence prevention programmes needs to be accompanied by investment in rigorous research, notably RCTs, with a particular focus on interventions designed in the UK. Studies need to: use sensitive and standardised measures to help with detecting change and synthesising findings; include longer-term follow-ups; and undertake mediation analyses to determine whether changing participants' knowledge, attitudes and bystander behaviour contributes to reduced victimisation and perpetration.

4. There is arguably some value in implementing media-based campaigns to increase awareness of IPV and relevant services and change knowledge and attitudes, and community-based interventions for pregnant teenagers or adolescent parents, but it should be recognised that the evidence for these is weak. In addition, investment in parenting programmes proven to reduce conduct disorders, later anti-social behaviour and/or child maltreatment has the potential to reduce the later experience or perpetration of IPV and sexual violence.

5. Preventing female genital mutilation (FGM)

Summary of key points

1. No studies were found that meet the inclusion criteria for this review. However, reviews of studies in countries in Africa with a high prevalence of female genital mutilation (FGM) are included, as there are women in the UK from countries where FGM is widely practised and their daughters are considered by experts to be likely to be at risk of FGM.
2. Various interventions were covered by these reviews, including multifaceted community activities, empowerment-based approaches and training for health professionals and female university students. There was some evidence of their effectiveness in changing participants' beliefs, knowledge and intentions regarding FGM but, where measured, no evidence that these changes translate into reduced prevalence of the practice among young girls.
3. As these were 'first-generation' studies, the reviews' authors expressed cautious optimism about possible progress. They advised that attending to programme implementation fidelity and cultural fit may increase acceptability and effectiveness.
4. This evidence comes with a clear health warning about its quality and transferability and a recognition of the need to consider types of research on preventing FGM in developed countries, including the UK, that lie beyond the inclusion criteria for the current review.

5.1 Introduction

The practice of FGM involves altering the genitals of young women for non-medical reasons and is recognised as a violation of the rights of girls and women (WHO, 2014). Specifically, it violates a person's rights to health, security and physical integrity, their right to be free from torture and cruel, inhuman or degrading treatment and, when the procedure results in death, their right to life. Awareness of FGM is increasing in the UK, and has been the subject of recent awareness-raising campaigns conducted by the UK government (HM Government, 2014; Department of Health, 2015). The risk of victimisation persists among many groups living in England who come from cultures where FGM is widespread.

It is estimated that FGM currently affects more than 125 million girls and women worldwide, concentrated in 29 countries in Africa and the Middle East, with 3 million at risk annually in Africa alone (WHO, 2014; Costello et al., 2015). It is widely acknowledged that FGM causes severe and irreparable physical and psychological

damage, with no health benefits (WHO, 2008; Rushwan, 2013). Recent systematic reviews and meta-analyses have found statistically significant associations between FGM and physical complications such as urinary tract infections and bacterial vaginosis (Berg et al., 2014a) and obstetric complications such as prolonged labour, caesarean section, haemorrhage and difficult delivery (Berg et al., 2014b). Another systematic review identified significant associations between FGM and painful sexual intercourse, no sexual desire and less sexual satisfaction (Berg and Denison, 2012a).

In communities where the practice is widespread, FGM is performed at any point from infancy to age 15 due to strong social convention and the belief that it is important in preparing the girl for marriage and adulthood and protecting her purity (WHO, 2014). It has been estimated that 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011 (MacFarlane and Dorkenoo, 2014). This is important because it is considered likely that the incidence of FGM in daughters of women from high-incidence countries will to an extent reflect the degree of risk in the countries of origin (Burrage, 2015). Bindel (2014) put the number of women and girls in the UK living with FGM at around 170,000 and estimated that 65,000 girls in the UK aged less than 13 years are at risk of mutilation. FGM thus presents a pressing safeguarding challenge for some communities in the UK.

The search process was unable to find any systematic reviews or primary studies meeting the inclusion criteria and focusing on interventions to prevent or reduce FGM in the UK or other high-income countries. However, 2 papers were identified that summarise the evidence for the effectiveness of interventions to counteract FGM. In both cases all of the included studies were conducted in parts of Africa where the practice is common. Given the absence of other suitable studies, and the earlier point about elevated risk among some population groups in the UK, these reviews are included here, with the obvious health warning about their applicability. The studies are reviewed below in terms of evidence of their impact and key messages for implementation. At the end of this chapter there is a brief discussion of relevant – but out of scope for this review – research in a UK context.

5.2 Systematic reviews

Berg and Denison (2012b) reviewed the effectiveness of interventions to reduce the prevalence of FGM. They searched for studies with a comparison group and found 8 diverse quasi-experimental design evaluations. All were classed as being of weak methodological quality and all were conducted in Africa in cultures where FGM is prevalent (Burkina Faso, Egypt, Ethiopia, Kenya, Mali, Nigeria, Senegal and Somalia). Collectively, the studies examined 4 types of intervention: training health professionals in attitudes towards FGM and care for women; educating female students to change their knowledge and beliefs; multifaceted community activities, including educational outreach and community-level advocacy; and empowerment through education for

women to develop a more participatory approach to stopping FGM. The interventions were targeted at health personnel, students (mean age 19), and village and community populations; although participants were adults, the interventions were designed to prevent FGM in their daughters, especially those aged 10 or under. Interventions lasted between 2 weeks at the individual level to 11 months at the community level, and were delivered in groups or one-to-one settings in various locations (clinics, a university, a refugee camp and villages).

The impact of the interventions was measured in terms of changes to knowledge, awareness, beliefs or attitudes, intentions to have a daughter cut, and – less frequently – behaviours and reported prevalence of FGM. Training health personnel was found to be ineffective for reducing the prevalence of FGM, although as the study was relatively old and had methodological weaknesses the authors suggested that knowledge and a sense of advocacy about FGM among health personnel in the country concerned may have risen subsequently. Educating female university students had positive effects in terms of increased beliefs that FGM violates human rights and increased knowledge of the harmful consequences of FGM; however, the prevalence of FGM among girls aged 10 and younger did not significantly change. There was some evidence from one study that the multifaceted community activities may have increased favourable attitudes and intentions towards FGM, with a statistically significant effect favouring the comparison group for the belief that FGM violates women's rights. However, the same studies showed evidence of statistically significant positive effects, including:

- the belief that FGM compromises the rights of women
- knowing the harmful consequences of FGM
- women encouraging someone not to perform FGM on their daughter and not intending to do it themselves either
- men not believing there are benefits to FGM

Finally, results for the village empowerment programme were mixed within and between studies; for example, one study found no effect (being opposed to FGM), whereas another found a statistically significant positive effect on, say, women's knowledge of the consequences of FGM but no effect on women's intention to have their daughters cut. Overall, there was no evidence that changes in beliefs, attitudes or intentions were translated into a change in prevalence of FGM among young girls. In total, 19 of 49 outcomes (with baseline similarity) were significantly different at study level, mostly favouring the intervention.

The authors advised caution about drawing conclusions given the considerable heterogeneity in the results, methodological limitations of the studies and shortcomings in implementation. That said, given that these were first-generation studies they expressed optimism that with sustained efforts it may be possible to end FGM within a few generations. Research recommendations included increased methodological rigour

in comparison group studies, such as ensuring baseline equivalence of treatment and comparison groups in terms of known prognostic factors, and using biological data from medical examinations rather than self-report or intention to perform FGM as an outcome measure. While these studies were all conducted in Africa, the findings and recommendations about understanding the cultural mores that drive the continued practice of FGM arguably have relevance for the UK. The authors recommended that "future intervention studies should be developed in partnership with local communities (and with the particular categories of individuals and institutions most appropriate for the setting) and be situated within appropriate historical, cultural, and policy contexts" (p.143).

The second review, by the same authors and published one year later, offered a realist review of interventions to prevent FGM, including more information on context and mechanisms to help explain the success and failure of interventions in terms of outcomes (Berg and Denison, 2013). It reviewed 35 studies, including 8 effectiveness studies[40] (controlled before-and-after) and 27 context studies. The findings reiterated those of the previous review in terms of study quality and effectiveness, suggesting that the success of interventions overall was limited. However, unlike the previous review the study also highlighted conditions that facilitated the success of FGM abandonment programmes in different contexts and that can be used in future prevention efforts to reduce the risk of girls being subjected to FGM (see sections 5.4 and 5.5 below).

5.3 Primary studies

No additional primary studies meeting the criteria were identified.

5.4 Implementation issues

Two main issues regarding implementation were identified. The first concerns implementation fidelity. Berg and Denison (2012b) suggested that one reason for the lack of evidence of effectiveness, at least for some types of intervention, could be low levels of exposure to the interventions. Similarly, Berg and Denison (2013) reported that increased exposure and higher levels of information dissemination were a key to success in FGM prevention interventions.

The second issue concerns the cultural fit of interventions. This is partly about who develops and delivers the interventions. When programmes are implemented by community outsiders who are ignorant of cultural nuance it can lead to lack of understanding between the implementers and the beneficiaries, thereby reducing the acceptability and effectiveness of a programme (Berg and Denison, 2012b). Accordingly, Berg and Denison (2013) advised that, "The involvement of skilled,

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[40] These were the studies included in the earlier review (Berg and Denison, 2012b).

community-based facilitators with background characteristics similar to those of the target population will help to ensure that the language and messages used are relevant, appropriate and make the target population relate better to a sensitive, context-bound issue such as FGM/C [Female Genital Mutilation/Cutting]" (p.332).

But the issue of cultural fit also involves the approach to intervening. In most of the interventions reviewed, the driving force for changing FGM-related behaviour was thought to be the dissemination of information, especially on the consequences of FGM for the individual concerned, in the belief that this would improve knowledge and in turn change attitudes. However, owing to the strong societal and cultural norms associated with FGM it is not this straightforward. In the light of this, Berg and Denison (2013) stated that, "gathering appropriate and sufficient data before developing a strategy to address a group's particular needs and wishes will facilitate a positive outcome" (p.332). They suggested that if, for example, there is a strong link between FGM and religion, the focus could be on religious interpretation of the custom's undesirability (involving religious leaders) rather than stressing health complications or human rights. Equally, they advised that where FGM is practised widely and is a deep-seated tradition, efforts might be framed in terms of related issues, such as parents' concern for the health and wellbeing of their daughters. In short, there is value in involving the local community and key opinion leaders, and questioning – rather than simply condemning – unhealthy societal norms.

5.5 Workforce skills and training

The review authors argued that training for the individuals delivering the interventions was often too short and that intervention effectiveness would benefit from using local health workers instead of community outsiders to educate women about FGM and its dangers (Berg and Denison, 2012b). However, this will be challenging. It was difficult to recruit and retain facilitators from the target communities, and training was also challenging for the trainee facilitators as they were uncomfortable with the lack of cultural fit of the content (Berg and Denison, 2013). The review authors therefore recommended addressing cultural sensitivities for future iterations of the programmes and developing strategies for training and retaining the workforce (Berg and Denison, 2013). As noted above, they also advised involving local opinion leaders, including religious leaders, to help with the design of interventions and also to help create a climate in which interventions are more likely to be effective.

5.6 Identifying children and young people in need of additional support

This issue was not discussed in the reviews covered in this chapter.

5.7 Summary

It was not possible to find any interventions targeting the practice of FGM in high-income countries that have been evaluated by randomised controlled trial (RCT), nor were any systematic reviews identified that include studies (including non-RCTs) of such interventions. The evidence reported here is therefore from systematic reviews of quasi-experimental studies in countries in Africa where the prevalence of FGM is high. Since there are women in the UK from countries where FGM is widely practised, and the daughters of such women are considered by experts likely to be at risk of FGM, it was decided to include this evidence here, with the obvious health warning about its transferability.

The studies in the 2 reviews included here involved different types of intervention, namely training health professionals, training female university students, multifaceted community activities and empowerment-based approaches. Collectively, studies showed some evidence of effectiveness in terms of changing participants' beliefs (for example that FGM violates a woman's human rights), knowledge (for instance of the harmful consequences of FGM) and intentions (to have one's daughter cut). However, there was no evidence that, where measured, these changes translated into a reduction in the prevalence of the practice among young girls.

Overall, findings were mixed, both within and between studies, and the review authors expressed concerns about shortcomings in implementation and methodological weaknesses in the research. But they noted that these were 'first-generation' studies and expressed cautious optimism about possible progress. They advised that interventions need to be implemented with stronger fidelity, as exposure was positively associated with success, and that attention is needed to the cultural fit of interventions to increase their acceptability and effectiveness (achieved, for instance, by involving local people in designing and facilitating interventions). Future research should be much more rigorous methodologically, measure the prevalence of FGM using biological data from medical examination and not self-report, and be developed in partnership with the local community.

Given that it was not possible to identify studies on the subject of FGM in the UK or other developed countries that meet the inclusion criteria for this rapid review, it is essential that other research on how to prevent and address FGM in those places be consulted in the course of formulating policy and practice guidance. For example, a study to inform work in Scotland involved a scoping literature review, interviews with key informants in the European Union, and consultation with stakeholders and women in affected communities in Scotland (Baillot et al., 2014). In terms of prevention,[41] the

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[41] The report also addressed the issue of the *protection* of children affected by FGM.

results pointed to the importance of the following for achieving sustained behaviour change:

- engaging with communities in a tailored fashion (this involves building trusting relationships)
- using appropriate and specific tools and materials, linking to participants' country of origin; recognising the role of community and emerging leaders, young people and men as agents of change
- raising awareness of FGM among the general public, policy makers and service providers – especially health professionals (including GPs, midwives, obstetricians, school doctors and paediatricians) and teaching and non-teaching staff in education settings from nursery upwards; incorporating FGM in the school curriculum in a non-stigmatising way
- making use of specialist NGOs

Another study provides an overview of approaches to preventing FGM in a UK context, such as work with diaspora communities, and school-based curricula (Burrage, 2015).

Implications for policy and practice

1. Owing to the absence of studies meeting the criteria for this rapid review, it is difficult to draw out from the studies included here firm implications for policy and practice regarding the prevention of FGM in England.
2. Ensuring cultural fit to the communities affected, for example by involving them in designing and facilitating interventions, is likely to be important for increasing intervention acceptability and effectiveness.

6. Preventing gang involvement and gang violence

Summary of key points

1. There is a lack of rigorous evaluation of the impact of interventions aiming to prevent gang membership and subsequent gang violence, especially in the UK. All of the studies included here were conducted in the US or Canada.
2. Universal, mostly school-based, gang prevention interventions have been found to produce some positive effects (notably on attitudes to gangs and the police) but generally show limited effectiveness (for example on initiation of gang membership, delinquency and crime rates).
3. Targeted community-based interventions for at-risk young people have been found to reduce some risk factors for gang membership, such as the initiation of marijuana use, but on the whole do not have significant effects on gang membership, arrests or drug use.
4. There is an absence of evidence for the effectiveness of cognitive-behavioural and opportunities provision approaches to preventing gang involvement.

6.1 Introduction

There is growing concern about gang membership in the UK and its relationship to violent crime. The definition of 'gang' is contested but broadly it refers to a group of young people who are involved, to some extent, in anti-social or criminal activity and share an identity of sorts (commonly based on name and/or territory) (Fisher, Gardner and Montgomery, 2008; Hodgkinson et al., 2009). The relationship between gang membership and violent crime makes this a pressing public health concern (Melde and Esbensen, 2012). Considering that violent crime in the UK is estimated to cost the NHS £2.9 billion per year, and bearing in mind the increasing contribution to this of youth gang-related gun crime in the UK, there is a strong case for effective interventions to prevent youth gang membership (Bellis et al., 2012).

The issue has been recognised by national policy makers in the UK, who have set out plans for preventing gang membership and gang violence, providing pathways out of gangs for young people who want to leave, and strengthening punishment and enforcement to suppress the violence of gang members (HM Government, 2011). More recently, the Early Intervention Foundation published advice on commissioning mentoring programmes to help prevent gang and youth violence (O'Connor and Waddell, 2015a). It reported that while mentoring has been shown to have promising

impacts on anti-social and criminal behaviour, evidence on its effectiveness in preventing or reducing gang membership is lacking.

This chapter considers the evidence on preventing and intervening early with gangs and gang-related violence, considering intervention effectiveness first and then key messages concerning implementation. It is important to note that the chapter is limited to gang involvement and gang-related violence, and that there are other reviews of what works to prevent and address youth violence more widely (see, for instance, Limbos et al., 2007; Matjasko et al., 2012; O'Connor and Waddell, 2015b).

6.2 Systematic reviews

Four systematic reviews were identified that summarise the evidence of effectiveness for interventions to prevent gangs and gang violence. Two of these reviews were unable to find any studies that met their criteria for inclusion. The first (Fisher, Gardner and Montgomery, 2008) sought to identify randomised or quasi- randomised trials[42] of cognitive-behavioural approaches to preventing youth gang involvement among young people aged 7 to 16 years not already in a gang. The second review (Fisher, Montgomery and Gardner, 2008) looked for similar studies in terms of design – randomised controlled trials (RCTs) and quasi-RCTs – but focused on interventions that involve providing young people of the same age (7 to 16 years) with opportunities (remedial education, tutoring, job training, job placement and so forth) to help prevent gang involvement. Both reviews sought to measure gang membership and gang-related delinquent behaviour and criminal offences as primary outcomes, and a series of secondary outcomes, ranging from illegal drug use to employment status. Owing to the lack of studies identified, the authors concluded that it is impossible to reach conclusions about intervention effectiveness in terms of preventing gang involvement. They advised that rigorous primary evaluations of cognitive-behavioural and opportunities provision approaches respectively to gang prevention are urgently needed to justify the funding of existing interventions and guide future gang prevention programmes and policies.

The remaining 2 reviews found few studies of high methodological quality. Hodgkinson et al. (2009) sought to identify comparison group studies of interventions to prevent or reduce gang-related anti-social behaviour or criminal activity, focusing on young people aged up to 25 years. They mapped 208 studies but conducted an in-depth review of 17 evaluations with a comparison group, none of which were RCTs and all of which were conducted in the US. To be included in the in-depth review, interventions needed to be multifaceted in the sense of including more than one type of intervention (such as educational, diversion, psychological, community mobilisation) and to target gang

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[42] Studies that randomise participants on the basis of, for example, alternate days, odd/even date of birth or hospital number.

members (there could also be other target populations, notably those at risk of gang membership). Between them, these studies measured various outcomes, but all measured reductions in crime, or changes in participant behaviour, or changes in attitudes of the community.

A meta-analysis focusing on crime reduction (involving 9 of the 12 studies that measured that outcome) found no statistically significant effect. Sub-group analyses showed that comprehensive interventions which include the mechanisms of personalisation, community involvement in planning and delivery, the sharing of expertise between agencies and/or the delivery of incentives to change offending behaviour (as part of a wider comprehensive intervention) may have a greater effect. It was not clear whether any of these elements are effective in isolation, or if more than one is needed to produce the positive effect. The authors concluded that there is insufficient evidence to justify a policy recommendation to use or not to use comprehensive interventions as a means of tackling gang violence. They recommended that future research should focus, first, on testing the identified mechanisms of change where potential effectiveness was identified, and, second, on rigorously evaluating comprehensive interventions in a UK context since the studies were all from the US (meaning that transferability is unclear).

The final review (Wong et al., 2012) focused on evaluations of strategies designed to prevent or reduce gang membership or gang-related delinquency or crime, limiting the geographical scope to Canada, the US, Australia and Europe. Among other forms of intervention that are less relevant for the current study, including interventions seeking to regulate the activity of gangs (targeting existing gang members), and prison-based initiatives, the review contained 10 studies in the area of prevention. These fall into 2 categories.

First are 5 studies (one RCT, 2 quasi-experimental design (QED), and 2 pre-post) of 3 universal preventive awareness programmes, which included school-based input to provide young people with knowledge about gangs and skills to resist gang membership, or offering recreational and job skills activities during the hours when young people may be more likely to commit a crime or to be victimised by others. These interventions were delivered by police officers or 'appropriate adult role models' in schools or the community. The 2 school-based interventions involved 13 to 16 classroom sessions delivered either weekly or over 2 years.

The second category involved 5 studies (3 QEDs, one interrupted time series, one pre-post) of 5 gang membership prevention programmes for at-risk populations (such as young delinquents or young people with low socio-economic status or living in at-risk neighbourhoods), which include school-based curricula or community-wide activities and a mix of inputs (recreation, education, job and life skills training, education and drug abuse treatment, and so on). These programmes were set in the community or schools

(including after-school). Programmes in both categories were delivered to young people in the 11 to 14 years age range.

The outcomes measured by the review were drug use, gang membership, gang avoidance, property offences, offences against the person and proxy measures such as truancy, academic performance, increased number of positive friends, self-efficacy and foster family support. The results were summarised in a narrative synthesis. Taking the first category of intervention, namely universal preventive awareness programmes, some positive effects were noted in terms of lower rates of gang membership and improvements in desirable attitudes towards gangs and police, but generally there was little sign of their effectiveness (for example on initiation of gang membership, teen victimisation, delinquency, crime rates, or engagement of teenagers in the community). The authors accounted for this by suggesting that these programmes were too broad in their reach, as the majority of recipients would never consider joining a gang in the first place.

As regards the second category of intervention, namely targeted community-based approaches for preventing gang membership, one intervention demonstrated reductions in gang membership and carrying a weapon, and another delayed the onset of gang behaviour and had a positive impact on other outcomes (including reduced likelihood of initiating marijuana use, elevated academic performance, and increased number of positive friends) but on the whole no significant effects were found for gang membership, arrests or drug use. The authors concluded that there are not enough evaluations of gang prevention interventions, and that those that do exist are not sufficiently rigorous for inclusion in a meta-analysis. Accordingly, they called for the development and rigorous evaluation of programmes based on empirical research findings rather than intuition or common sense, including targeting research-based factors for gang membership. They advocated (i) a 'less is more' approach – targeting the most pressing issue and achieving small victories instead of trying to tackle every problem at once, and (ii) the use of research-based delinquency prevention programmes rather than specific gang membership prevention programmes (such as GREAT: Gang Resistance Education and Training), which was one of the preventive awareness programmes included in the review).

6.3 Primary studies

One RCT of a gang prevention programme that had not been included in the systematic reviews discussed above was identified. Esbensen et al. (2012, 2013) conducted an RCT in the US of GREAT. The programme targets early adolescents with the aims of preventing gang membership, violence and criminal activity and helping young people to develop positive relationships with law enforcement. It is taught primarily by uniformed police officers in schools and involves 13 weekly 40-minute lessons. The programme content addresses a range of issues, such as school commitment, self-

control, conflict resolution skills, goal-setting and association with prosocial peers. The trial involved 31 schools from 7 cities, with 195 classrooms allocated to intervention (n=102) or control (n=93) groups. Participants were 3,820 children in 6th or 7th grades (ages 11 to 13). A range of measures of behaviour, attitudes and skills were assessed at baseline, post-test and 12 months and 4 years post-intervention.

Short-term results (averaged over post-test and 12 months post-intervention) showed a reduction in the odds of gang membership of 39% for the GREAT group relative to the control group and more positive attitudes towards police (a small effect) but no effect on violent offending or general delinquency (Esbensen et al., 2012). There were also positive effects on 8 out of 26 proximal measures of skills/attitudes, including refusal skills, resisting peer pressure, being less self-centred, and expressing less positive attitudes towards gangs. No impact was observed, however, for the other 16 attitudinal measures (including empathy, risk-seeking, problem-solving and negative peer commitment). The authors concluded that although effects were mixed, and the positive effects were small, the programme is promising, particularly since it only involves 13 class periods, and as such "can be effectively included as a primary prevention component of a larger community-wide effort to reduce gang membership and youth violence" (p.144).

At 4 years post-intervention, there was some evidence of a sustained impact, with a 24% reduction in the odds of gang membership relative to the control group and positive effects for some skills and attitudes: 8 out of 10 differences (p<.05 for 3, p<.10 for 7) were also evident at the 12-month follow-up, indicating a sustained long-term effect on those outcomes (Esbensen et al., 2013). The effects were smaller than at the earlier time point. Again, the authors concluded that GREAT is no panacea for gang problems but that it holds promise as a primary gang prevention programme. They attributed its effectiveness in part to strong implementation fidelity but also to a redesign that saw the earlier didactic delivery model – used in the Esbensen et al. (2001) study, which was covered in the Wong et al. (2012) review and found no evidence of effect at one year post-intervention – replaced by an emphasis on skills building and cooperative learning strategies.

6.4 Implementation issues

Although it is recognised in the reviews covered in this chapter that there is no single cause or easily identified factor that could be addressed to reduce the risk of gang membership or violence at a population level, the more specific the targeted population the more evaluations tended to show signs of effectiveness – albeit this was still limited (Wong et al., 2012). Further to this, research-based risk factors for gang membership should be used as guidance for programme delivery and dosage (Wong et al., 2012).

In terms of content, one review found that interventions which offered incentives (with or without sanctions) record a statistically significant positive result, while the evidence for interventions providing sanctions on their own was weaker (Hodgkinson et al., 2009). It also found that interventions using marketing/publicity or problem-solving approaches showed positive, albeit not statistically significant results, and that a personalised or tailored holistic service appeared to produce a consistent, positive and significant effect.

In terms of how interventions are managed, involving community members in the planning and delivery of the intervention appears to increase ownership and there is a suggestion that this may increase community efficacy regarding gang membership and violence (Hodgkinson et al., 2009). Specifically, it improves understanding of the problem and, because the community feels empowered and listened to by people in positions of power, increases their motivation to address the problem.

6.5 Workforce skills and training

There was evidence that multi-agency working and sharing expertise between agencies can increase effectiveness, and a suggestion that the involvement of the community should extend to being actively involved in delivering aspects of the intervention or otherwise simply supporting those that do (Hodgkinson et al., 2009).

6.6 Identifying children and young people in need of additional support

Wong et al. (2012) recommended that prevention should begin as early as age 9, as children tend to join gangs in grades 8 to 10 (aged 13 to 16 years), although primary prevention may not be effective or a good use of resources, since they target many young people but only a tiny proportion of those will be at risk of joining a gang.

In terms of risk factors, the most significant one is prior delinquency, so it has been suggested that children or young people who have been involved in delinquency are monitored to help identify those who are more likely to join a gang (Wong et al., 2012). Other risk factors are: the importance of delinquent friends; non-delinquent problem behaviours; a series of negative life events; favourable attitudes about breaking the law; a lack of parental supervision; a lack of parental monitoring; and a commitment to negative peers (Wong et al., 2012).

6.7 Summary

The main message from the reviews in this chapter is arguably that there is a dearth of rigorous evaluation of the impact of interventions aiming to reduce gang membership and subsequent gang violence. Interpretation of the findings also needs to take into account possible issues with transferability, since all of the studies in the systematic reviews – and the single primary study – were conducted in the US.

The effectiveness of universal prevention interventions appears to be in question, as the majority of young people are not at risk of participating in gang violence. Such programmes, which are mostly school-based, were found to produce some positive effects (for example on attitudes to gangs and the police) but generally show limited effectiveness (for example on initiation of gang membership, delinquency and crime rates). The most recent RCT of the (universal) GREAT programme offered some promise, however, showing a reduction in the odds of gang membership sustained to 4 years post-intervention, possibly owing to its emphasis on skills-building and cooperative learning strategies.

Targeted community-based interventions for at-risk young people have been found to be effective in reducing some risk factors for gang membership, such as the initiation of marijuana use, but on the whole they do not have significant effects for gang membership, arrests or drug use. A meta-analysis of programmes targeting gang members (but also potentially including other participants, including those at risk of gang involvement) found no statistically significant impact on crime.

The inclusion of a more personalised approach, the involvement of the community in intervention planning and delivery and the sharing of expertise between agencies may increase the effectiveness of interventions, in addition to the delivery of incentives to change behaviour. It was suggested in the literature examined that targeting and monitoring young people who demonstrate delinquent behaviour – the main risk factor for gang involvement – will help to focus interventions more efficiently, particularly when used in conjunction with delinquency prevention programmes (as opposed to specific gang membership prevention programmes). It was also recommended in one review that prevention begin as early as age 9, as children tend to join gangs aged 13 to 16 years.

These latter recommendations are echoed in the wider literature. It is true that young people become involved in gangs for reasons over and above those underlying criminal activity, for example because a gang provides social support, elevated status, excitement and protection from threats (Wood and Alleyne, 2010). However, most young people who join a gang have a history of involvement in crime and anti-social behaviour, so preventing the onset of such behaviour can reduce gang joining (Howell and Griffiths, 2016).[43] Indeed, future gang members share several of the risk factors evident in future serious and violent adolescent offenders, such as family and school problems, association with anti-social peers, and drug and alcohol use. A long-term perspective to reducing gang involvement and gang-related violence would therefore involve fulfilling children's developmental needs from early childhood onwards in the

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[43] There are numerous syntheses of the evidence on what works to prevent anti-social behaviour and crime among children and young people, including a recent summary of systematic reviews (see Farrington et al., 2017).

individual, family, school, peer, and neighbourhood domains (Howell and Griffiths, 2016).

Implications for policy and practice

1. With the possible exception of GREAT, there is not a strong case for implementing universal school-based gang prevention programmes. The same applies to targeted community-based gang prevention interventions.
2. Since delinquent behaviour is the main risk factor for gang involvement, it is suggested that targeting and monitoring young people who demonstrate such behaviour will help to focus interventions more efficiently, particularly when used in conjunction with delinquency prevention programmes (as opposed to specific gang membership prevention programmes).
3. Preventing gang involvement and gang-related violence is likely to involve seeking to meet children's developmental needs from early childhood onwards, and acting in the individual, family, school, peer and neighbourhood domains to address risk factors such as family and school problems, association with anti-social peers, and drug and alcohol use.
4. Factors considered likely to increase the effectiveness of interventions include a personalised approach, community involvement in planning and delivery and sharing expertise between agencies.

7. Economic analysis

Summary of key points

1. Longitudinal studies indicate that child abuse and neglect can be linked to a wide range of longer-term adverse outcomes relating to employment, years of education, mental health problems and substance use.
2. When interventions delivered to children in the 5 to 19 age range are effective in preventing or reducing child abuse and neglect, the effects lead to monetary benefits across many sectors, reflecting improvements in outcomes across the child's life.

7.1 Introduction

In order for the case to be made for commissioning universal or selective interventions, it is helpful to have information about the financial benefits that can come from improving outcomes alongside the more intangible benefits, such as improved mental health and wellbeing over the life-course of the child. Most trials of interventions typically only measure outcomes in the short term (that is, within a year or 2 of the completion of the intervention). However, outcomes that are sustained in the longer term and later life, such as earnings and criminal behaviour, are more likely to have economic implications for children, their families and society. Economic modelling is therefore necessary to extrapolate what is likely to happen in the long term, given what is known about short-term outcomes.

The costs of programmes and the amount of benefits that can be expected will vary depending on the needs of the target population of each programme. Universal programmes are aimed at the general population. As the probability of problems occurring in the general population is relatively low in general, the amount of change from base rates that can be expected is low, but interventions are also likely to be less intensive and cost less to implement. By contrast, targeted preventive interventions are delivered to children and families where there is a greater likelihood of future problems, or early signs of problems. These interventions may therefore need to be more intensive and thus more expensive, but they could have a large impact as they are delivered to those children and families most likely to have the problems they address. Intervention at both the universal or targeted levels is important in order to address problems before they begin or before they worsen. Detailed cost-benefit analysis can provide more information about the best investments at all levels by combining information about the costs and effects of interventions and the risk of poor outcomes for different populations and the likely trajectories of these problems over the life-course.

The following review identifies some of the key links between short- and long-term outcomes and, for a selection of discrete interventions that cover the 5 to 19 years age range, shows how these translate into long-term economic benefits. The first section (7.2) provides a summary of a review of the systematic reviews conducted by the Washington State Institute for Public Policy (WSIPP) that analyse the effects of child abuse and neglect on longer-term outcomes. The analysis shows what these relationships look like, with details provided from a selection of the studies analysed in these reviews to illustrate what they mean in real terms. The second part (7.3) provides details of cost-benefit analyses conducted by the Dartington Social Research Unit (DSRU) for selected interventions that are delivered within the 5 to 19 age range.[44] These include a summary of how effects on particular short-term outcomes result in monetary benefits from change in longer-term outcomes – for example, the prevention or reduction of child abuse and neglect leading to reduced depression and increased earnings.

7.2 The relationship between short-term intervention effects and long-term outcomes

WSIPP conducts systematic reviews of longitudinal research to establish causal links between short-term outcomes that are measured in trials and longer-term outcomes that have economic implications (WSIPP, 2016). As these reviews are ultimately used to create forecasts of the benefits of investment in interventions for real-world decision-making, 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 specific 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). There also has to be sufficient confidence in the measurement and reporting of both outcomes and the relevance of the population in the study to those receiving the interventions, and the study must include a comparison group to establish an effect size. These effects are ultimately applied to a model containing information about the probabilities and trajectories of the targeted problems over the life-course of each population. For example, the model includes the likelihood of onset and persistence of alcohol problems in a general population as well as a population with diagnosed alcohol use disorders, based on real data from longitudinal cohort studies. The model therefore takes into account these causal relationships as well as the real probability of mental health, addiction, crime, and other problems over the lifetime of the child.

The analyses to date have included 38 studies that have identified significant causal links between child abuse and neglect and several long-term outcomes, which are

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[44] See www.investinginchildren.eu

presented in Table 7.1. WSIPP has not analysed the long-term effects following on from other outcomes of interest to this review.

Table 7.1 Causal links between child abuse and neglect and long-term outcomes

Predictor	Long-term outcome	Number of studies	Effect size (ES)	Standard error (SE)
Child abuse and neglect	PTSD	1	0.84	0.20
	Crime	11	0.54	0.07
	Disruptive behaviour	1	0.46	0.39
	School completion	5	-0.40	0.10
	Special education	1	0.39	0.04
	Tobacco (regular use)	1	0.39	0.12
	Anxiety	3	0.33	0.17
	Depression	8	0.29	0.06
	Illicit drugs (disordered use)	6	0.27	0.07
	Test scores	3	-0.27	0.07
	Employment	3	-0.26	0.09
	Years of education	1	-0.24	0.11
	Alcohol (disordered use)	6	0.17	0.05
	Obesity	5	0.04	0.04

Two of these studies (Lansford et al., 2002, 2007) report findings from The Child Development Project, based in the US states of Indiana and Tennessee, which first assesses children at age 5 and follows them into adulthood. They provide information about how child physical abuse predicts long-term outcomes, including many that have economic implications, such as school completion, crime and standardised test scores of maths and language. When the effects identified by these studies are isolated from the larger meta-analyses, the only significant effect of child maltreatment was on the rate of school completion (ES=-0.85, SE=0.17), which has implications for future economic outcomes such as further education, employment and earnings (Lansford et al., 2007).

Another included paper reported on the association of child abuse and neglect with obesity up to midlife in the 1958 British Birth Cohort (Power et al., 2015). The researchers examined whether child maltreatment was related to obesity over the life-course from ages 7 to 50 years. Child abuse was reported in 12% of the sample (n=9,377) and childhood neglect was reported in 20%. The association between maltreatment and body mass index (BMI) or obesity was found to vary by type of maltreatment and by age. The associations were all found to be weak or not present in childhood, but some stronger associations were found when the respondents were older. Inverse associations were found between physical abuse and obesity, with lower than average BMIs associated with physical abuse in childhood, but with physical abuse leading to higher than average BMIs in adulthood (in males at age 7 Odds Ratio (OR) = 0.47; at age 50 OR = 1.42; in females age 7 OR = 0.34; at age 50 OR = 1.67). In

females, the same type of inverse association between sexual abuse and obesity was found (at age 7 OR = 0.23; at age 50 OR = 1.34). Children who had experienced neglect were more likely to have a lower BMI than children who had not at ages 7 and 11 but were more likely to have a higher BMI at older ages, peaking at age 33 in both males and females. However, no associations between neglect and obesity were found after controlling for covariates. This study provides a good example of an important consequence of child maltreatment that might not be discovered using concurrent assessments of outcomes, but which appears and grows stronger as the child becomes an adult.

In another included paper, researchers conducted a prospective study of a cohort in New Zealand (mean age = 11.5) and found significant associations between child maltreatment and several mental health disorders in adulthood (Scott et al., 2010). Even when compared to adults with no social services records indicating maltreatment, including those who reported childhood maltreatment retrospectively but had no social services records, those with a documented history of involvement with social services due to child maltreatment had significantly greater odds of having 5 different mental health disorders as adults: dysthymia (OR = 3.13), specific phobia (OR = 1.83), social phobia (OR = 2.14), posttraumatic stress disorder (OR = 5.12) and obsessive compulsive disorder (OR = 4.00). These odds increased when the children with self-reported but not documented child maltreatment were removed from the comparison group. The odds of 2 additional disorders also became statistically significant: major depressive disorder (OR = 2.23) and drug abuse/dependence (OR = 3.15). These odds ratios were adjusted for potential confounders, such as socio-economic status. This study indicates that child maltreatment, not just the memory of child maltreatment, is associated with mental health disorders in adulthood, providing evidence that preventing maltreatment or the recurrence of maltreatment could have long-term implications for the well-being of children over their lifetimes.

7.3 Monetary benefits deriving from short-term outcomes

The aforementioned links from short-term outcomes in trials to longer-term outcomes form the foundation for estimates of many of the monetary benefits of interventions over the life-course for a wide range of areas. In addition, some outcomes can be monetised directly by modelling the persistence of problems over the life-course alongside data on how these outcomes predict factors such as service use patterns and earnings.

The 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 methods developed by WSIPP are therefore used to make these estimates. These methods use real data as much as possible and are driven by the measurements in trials of effects of the interventions on outcomes. The size of the effect is used to estimate the unit change in each long-term outcome that can be expected when applied to the trajectories of the

outcomes over the life-course of the relevant population. The value of that unit change is then estimated in monetary terms. The overall aim is to estimate how much a change in outcomes (such as a reduction in early conduct problems) is worth, respectively, to the public sector, children receiving the intervention and others in society. The cost-benefit methods follow these steps (elaborated in Little et al., 2013):

1. The research literature is reviewed and the size of the impact of each intervention on outcomes for children is calculated. The size of this effect is reduced where there are methodological weaknesses or other sources of bias that would indicate that a smaller effect would be expected in a real-world implementation of the intervention.
2. The size of the link between short-term outcomes and longer-term monetisable outcomes is estimated.
3. These 2 types of effect sizes are used to estimate how much change in an outcome can realistically be achieved for each intervention when it is provided to children or families in the UK, given the base rates of outcomes over the life-course in the populations targeted by each intervention (for example the probability of onset and persistence of mental health problems or addiction).
4. The monetary value of the change is estimated in a range of areas that can be causally linked to the outcomes. For example, a reduction in ADHD (attention deficit hyperactivity disorder) can be linked to savings in health care costs, education costs, criminal justice system costs, and increased earnings and taxes paid. This value is estimated for the projected lifetime of the child and then discounted to compute a net present value. The model uses a range of real discount rates to compute net present values. The discount rates are applied to all annual benefit and cost cash flows and economic impacts arising in future years are converted to present values. The model uses low (2%), modal (3.5%), and high (5%) discount rates in computation.
5. The costs of each intervention per child per year are estimated.
6. An analysis of the uncertainty in each of the steps in the cost-benefit analysis is carried out to test the likelihood of a net gain or loss from investment in each intervention. To do this, estimated ranges of uncertainty around key inputs in the model are included and then varied in Monte Carlo simulations. The inputs that are varied in the model include: programme effect sizes, linked effect sizes, discount rates, programme costs, criminal justice and victimisation costs, value of a statistical life, and labour market earnings from improvements in educational outcomes.

For those interventions subjected to analyses using the UK cost-benefit model that (i) are delivered in the 5 to 19 years age range, and (ii) have studies measuring impact on child abuse and neglect, Table 7.2 shows how effects on 2 short-term outcomes (child abuse and neglect, and out-of-home placement) are predicted to produce monetary benefits on average over the participant's lifetime. It is important to make 3 comments about this analysis. First, the effect sizes come from analyses conducted by WSIPP (Lee et al., 2012). Second, since the purpose of the analysis is to show how effects on

child maltreatment in the short term have an impact in the longer term in terms of costs, the analysis is not restricted – unlike the rest of this report – to prevention and early intervention programmes. Third, the focus is on child abuse and neglect only, as the DSRU cost-benefit model cannot yet monetise other outcomes covered in this report, notably reductions in domestic or dating violence, sexual exploitation or gang violence.

For example, in the case of Homebuilders (programme 2 in Table 7.2), 5 trials measured its effect on the recurrence of child abuse or neglect and out-of-home placement, compared to a control group. The results were combined in a meta-analysis of this outcome, and the weighted mean effect size on child abuse and neglect was -0.23 (SE = 0.11), indicating a small effect. This effect size was then reduced slightly using an empirically derived system of discounts to form a more realistic estimate of the likely effect of Homebuilders in the real world (ES = -0.19) rather than in a research setting. Using the results from the analyses linking short- and long-term outcomes, the model can calculate how much change in crime reduction, increased earnings, reduced need for social work services, reduced need for special education and reduced health care costs can be expected given that effect size, compared with what would be expected without the intervention. It then places a net present value on that change in terms of the benefits that Homebuilders is likely to yield per child over his or her lifetime.

The programmes in Table 7.2 are provided to children in the 5 to 19 years age range and their families, although provision extends to earlier years as well. The outcomes presented here are those that are relevant to the UK and that can be monetised in terms of future benefits using the DSRU cost-benefit model. These programmes may have positive impacts in other areas, but this work is limited to the outcomes that have been measured in trials and that can be linked to monetary benefits in studies meeting the inclusion criteria and using the methodology outlined above.

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 society (such as potential victims of crime). The taxpayer benefits consist primarily 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.[45]

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[45] The website http://www.investinginchildren.eu provides a more detailed breakdown of these benefits for each programme.

Table 7.2 Short-term outcomes and lifetime monetary benefits by programme

1. Alternative response

Alternative Response, also called differential response, multi-track response, and dual-track response, is an alternative to standard child protection assessments and investigations. The programme invites greater participation by community services in supporting families who are considered to be low-risk, aiming to allow social services to focus on more serious cases in which abuse and neglect have been confirmed. These approaches allow families to 'step up' to increased services and monitoring, or 'step down' to less intervention, as their needs change (determined by on-going assessment).

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Child abuse and neglect	-0.09	0.03	Crime	£35
			Social Services	£142
			Special Education	£16
			Health care	£10
			Earnings	£165
Out-of-home placement	-0.30	0.12	Out-of-home placement	£185
Benefits Minus Costs	**£474**			
Cost-benefit Ratio	**6.93**			

2. Intensive Family Preservation Services (Homebuilders)

Intensive Family Preservation Services (Homebuilders) provide intensive, in-home crisis intervention, counselling and life-skills education for families who have children (aged birth to 17 years) at imminent risk of being placed into care. The programme emphasises contact with the family within 24 hours of the crisis and aims to prevent the removal of a child from his or her biological home (or to promote his or her return to that 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, 7 days a week.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
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
Benefits Minus Costs	**£7,888**			
Cost-benefit Ratio	**3.95**			

3. Other Family Preservation Services (non-Homebuilders)

'Other' Family Preservation Services (FPS) programmes have the same goals as 'intensive' FPS, namely to prevent the removal of a child from his or her biological home (or to promote his or her return to that home) by improving family functioning. However, other FPS programmes lack the rigorous criteria for implementation as defined by the Homebuilders model. Programmes target families who have children aged 0 to 17 years and aim to improve family functioning.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
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
Benefits Minus Costs	**-£2,873**			
Cost-benefit Ratio	**0.16**			

4. Parent Child Interaction Therapy for families in the child welfare system

Parent-Child Interaction Therapy (PCIT) is targeted at children aged 2 to 12 years and their parents and focuses on increasing positive parent behaviours and improving the quality of the parent-child relationship. Parents first receive a 6-session orientation group to increase their motivation to participate, before receiving the standard treatment, which typically comprises 12 half-hour weekly sessions and a one-hour booster session one month after treatment ends. Parents are taught traditional play therapy skills to improve parent-child interactions and also learn problem-solving skills to manage new problem behaviour. They practise communication skills and behaviour management with their children in a playroom while coached by therapists.

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
Benefits Minus Costs	**£1,310**			
Cost-benefit Ratio	**2.03**			

5. Triple P Positive Parenting Programme (All Levels)

This version of the Triple P behavioural parenting intervention comprises 5 levels: a universal media-based communications strategy (Level 1); seminars for parents interested in promoting their child's development or individual consultations for those with specific concerns about their child's behaviour (Level 2); parenting guidance and support delivered in primary care (Level 3); and group-based or individual sessions for parents of children with identified behaviour problems (Levels 4 and 5).

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Child abuse and neglect	-0.14	0.00	Crime	£25
			Earnings (including taxes)	£147
			Social services	£99
			Special education	£11
			Health care	£9
Out-of-home placement	-0.31	0.00	Out-of-home placement	£306
Benefits Minus Costs	**£478**			
Cost-benefit Ratio	**5.05**			

Collectively, the results in Table 7.2 show how, in many cases, improvement in one early outcome, and reduction in child maltreatment in particular, can yield future benefits in many different areas in a child's life. In addition, some outcomes lead to benefits via multiple other intermediate steps. For example, a reduction in child abuse and neglect can lead to savings for social services but also increased earnings for the individuals concerned via subsequent improved test scores, attainment of higher levels of education or reduced depression.

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.

There is clearly considerable variation in the cost-benefit ratios across the programmes described above. This can be the result of a mismatch between the intensity – and therefore cost – of a programme and the risk of poor outcomes in the target population, or simply due to the small effect sizes found in trials of the intervention. It can also arise because some outcomes are not yet monetisable in this model, such as problem drinking or tobacco use, so some interventions may make important changes for children that cannot be accounted for in terms of monetary benefits. When commissioning these types of interventions, the information about costs and benefits

must always be considered alongside the wider evidence for their impact on the wellbeing of children and families and considerations of fit with the local context.

7.4 Summary

The economic analysis presented in this chapter consisted of 2 parts. The first part reviewed the systematic reviews conducted by WSIPP that analysed the effects of child abuse and neglect on longer-term outcomes from 38 longitudinal studies. The results indicated that child abuse and neglect can be linked to a wide range of longer-term outcomes, such as employment, years of education, mental health problems and substance use. Three studies from these systematic reviews that include outcomes for children aged 5 to 19 years were identified to illustrate what these links from short-term to long-term outcomes look like in real terms. These studies showed that the sequelae of child abuse and neglect are not always evident until much later in life.

In the second part of the economic analysis, cost-benefit analyses were used to determine whether intervention effects on child abuse and neglect resulted in monetary benefits in the longer-term. The cost-benefit ratios of 5 interventions that focus on these outcomes in 5 to 19 year-olds ranged fairly widely, with one programme resulting in a negative return on investment (£0.16 return for every £1 spent). The remaining 4 programmes resulted in benefits ranging from £2.03 to £6.93 of return for every £1 spent. The results showed that, when interventions are effective, reductions in child abuse and neglect lead to monetary benefits across many sectors, reflecting improvements in outcomes across the child's life.

Implications for policy and practice

1. Investing in programmes that are proven to prevent or reduce child abuse or neglect will likely lead to monetary benefits across many sectors, reflecting improvements in outcomes across the child's life.

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