Child Abuse & Neglect xxx (xxxx) xxx

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg

The value of a modular, multi-focal, therapeutic approach to addressing child maltreatment: *Hope for Children and Families Intervention Resources* – a discussion article

Arnon Bentovim [a,b,*], Bruce F. Chorpita [c], Eric L. Daleiden [d], Jenny Gray [e,f], Stephen Pizzey [e], Eileen Vizard [g,h]

[a] *Child and Family Training, PO Box 723, York, Y030 7WS, UK*
[b] *Royal Holloway University of London School of Biological Sciences, Egham, Surrey, UK*
[c] *Department of Psychology, University of California, Box 951563, Los Angeles, CA, 90095, USA*
[d] *PracticeWise, LLC, 340 Lee Ave Satellite Beach, FL, 32937, USA*
[e] *Child and Family Training UK, PO Box 723, York, Y030 7WS, UK*
[f] *UCL Great Ormond Street Institute of Child Health, 30 Guilford St, London, WC1N 1EH, UK*
[g] *UCL Great Ormond Street Institute of Child Health, 30 Guilford St, London, WC1N 1EH, UK*
[h] *New York University in London, London, UK*

ARTICLE INFO

Keywords:
Adverse Childhood Experiences (ACEs)
Child maltreatment
Common elements approach
Prevention
Modular treatment

ABSTRACT

This discussion article begins by highlighting two trends apparent in the field of child maltreatment. The first, an awareness that multiple forms of maltreatment – polyvictimization - is the rule in populations of abused and neglected children rather than the exception. The second is that current types of child maltreatment are being extended to include Adverse Childhood Experiences (ACEs). These include intra-familial violence, mental health, substance misuse, and inter-generational abuse. The paper introduces an innovative strategy to help the field better organise and prevent the extensive sequelae of polyvictimization and ACEs. This strategy involves the development of a modular approach, which identifies common treatment elements and common factors across the field of effective interventions and organizes them, providing a co-ordinated framework for practitioners to use to address the diverse needs of children and families when vulnerability or maltreatment are identified. The development of this approach, the *Hope for Children and Families* (HfCF) *Intervention Resources,* is described using a case example to illustrate its logic and structure. Findings from the HFCF pilot and subsequent training programs suggest that this new approach could be an important milestone in the protection of children from violence, abuse and neglect on the 30th Anniversary of the United Nation's Convention on the Rights of the Child (1989).

1. Introduction

This discussion article highlights two trends apparent in the child maltreatment field and presents an illustration of how the

* Corresponding author at: Child and Family Training UK, PO Box 723, York, Y030 7WS, UK.
E-mail addresses: arnon.bentovim@childandfamilytraining.org.uk (A. Bentovim), chorpita@ucla.edu (B.F. Chorpita), e.daleiden@practicewise.com (E.L. Daleiden), jennifer.gray@ucl.ac.uk (J. Gray), Stephen.pizzey@childandfamilytraining.org.uk (S. Pizzey), e.vizard@ucl.ac.uk (E. Vizard).

https://doi.org/10.1016/j.chiabu.2020.104703
Received 23 December 2019; Received in revised form 13 June 2020; Accepted 18 August 2020

adoption of a modular approach to intervention may help the field better respond to these trends. As a society we are witnessing a broadening of the concept of child maltreatment. Finkelhor described "polyvictimization" (Finkelhor, Omrod, & Turner, 2007), i.e, young people who described being exposed to multiple forms of maltreatment over their childhood. Responses to earlier child maltreatment (e.g. including anger and aggression) puts them at risk of further victimization. Their families are more likely to be characterised by interpersonal violence, disruption and adversity. The reality of child maltreatment is that complex overlapping forms of maltreatment are the rule, rather than the exception (Bentovim, Vizard, & Gray, 2018; Debowska, Willmott, Boduszek, & Jones, 2017). Herrenkohl and Herrenkohl (2009), in their review of the frequency of multiple maltreatment across populations of identified abused children, described a range of polyvictimization between 33–94 % depending on the child's social context.

Following their Adverse Childhood Experiences (ACEs) study, Felitti et al. (1998) added household dysfunction and instability resulting from domestic violence, parental substance abuse, mental illness, imprisonment and separation to the basic forms of child maltreatment. Finkelhor, Shattuck, Turner, and Hamby (2012) described additional sources of adversity in childhood including bullying, someone close having a bad accident, death or illness, parents arguing, having below average grades, and a lack of good friends. Ellis and Deitz (2017) drew attention to Adverse Community Experiences, e.g., violence, poor housing, poverty, community disruption, discrimination, lack of opportunity, and climate change. The more ACEs reported in childhood, the greater the risks of engaging in health-harming behavior and infectious and non-communicable diseases throughout the life-course (Hughes et al., 2017). Their cost to society is enormous (Bellis et al., 2019).

There are limitations to an "additive model" of ACEs, i.e., the assumption that each adversity is equally important for individual outcomes (Lacey & Minnis, 2019; McLaughlin, Sheridan, & Lambert, 2014). However, summing variables acknowledges the high level of co-occurrence of childhood adversity (Finkelhor et al., 2007). In children and young people, a graded cumulative relationship is described between the number of ACEs, and associated poor health, somatic complaints and a variety of health and behavioral problems (Flaherty et al., 2013). Multiple ACEs are associated with (a) children identified as abused and neglected (Garcia, Gupta, Greeson, Thompson, & DeNard, 2017), (b) depression, withdrawal, and rule-breaking behaviour in children in alternative care (Villodas et al., 2016), (c) suicidal ideation in adolescence (Thompson et al., 2012), (d) delinquency or offending behaviour (Baglivio et al., 2014), and (e) lifetime re-offending (Craig, Piquero, Farrington, & Ttofi, 2017).

This knowledge about the antecedents of child maltreatment and ACEs is well established. There are evidence-based approaches to decrease the impact of child abuse and neglect, and the impact of ACEs in the next generation. However, the majority of interventions focus on single forms of maltreatment and ACEs and are less effective with polyvictimization and multiple ACEs. Van IJzendoorn, Bakermans-Kranenburg, Coughlan, and Reijman (2020) undertook an umbrella synthesis of meta-analyses of child maltreatment antecedents and interventions. They concluded that to date there has been a failure to achieve a central tenet of the United Nation's Convention on the Rights of the Child, namely, Article 19 - children's right to be protected from all forms of violence, abuse and neglect. In order to contribute to Governments' and civil societies' fulfillment of Article 19, practitioners across the fields of social care, health, education, and juvenile justice need to be aware that children and young people referred to their services may have been subjected to polyvictimization and multiple ACEs. Hence, these factors need to be considered as key elements in a comprehensive assessment and analysis of their developmental needs and subsequent choice of interventions.

2. Aims of this discussion article

The aims of this article are to discuss how effective interventions can be developed to prevent or decrease child abuse and neglect in the next generation, and to support fulfillment of the goals of the United Nations Convention on the Rights of the Child, by:

1 Reviewing the strengths and limitations of current interventions to address polyvictimization, and the broadening focus to ACEs from targeted single forms of maltreatment;
2 Discussing how a modular approach may help the field to organize and address these trends;
3 Setting out the developmental process for the *Hope for Children and Families* (HfCF) *Intervention Resources* and illustrating how to use them in a specific case;
4 Presenting results from piloting and initial implementation of the HfCF Intervention Resources; and,
5 Discussing the strengths and limitations of a modular approach to provide the workforce with the resources to support effective implementation of the United Nations Convention of the Rights of the Child.

3. How effective are the therapeutic approaches to prevent maltreatment?

3.1. Evidence on risk factors and prevention

Van IJzendoorn et al.' (2020) umbrella synthesis of meta-analyses of child maltreatment antecedents and interventions concluded that there was now good evidence to identify parental risk factors for maltreatment. These risk factors include parents who have themselves been victims of child maltreatment, been subjected to interpersonal violence, had negative personality attributes associated with mental health disorders, and have limited social and material resources.

However, they noted there was a *"'power failure' of interventions to prevent or decrease child abuse and neglect in the next generation, with the effect sizes for intervention being substantially smaller than the effect sizes for most of the antecedents of child maltreatment"* (Van IJzendoorn et al., 2020, p. 283). They further commented, "*the scarcity of evidence-based means to break the circle of maltreatment is deplorable. Child maltreatment is a widespread global phenomenon affecting the lives of millions of children all over the world, which is a*

betrayal of the United Nations Convention on the Rights of the Child (United Nations, 1989)" (p. 284).

Hughes et al. (2017) argue that in addition to within health services, "*ACE-informed practice can be developed across multiple settings, including schools, criminal justice agencies and social care*" (p. e364) and, in contexts of concern when children show evidence of being subjected to maltreatment, with associated parental mental health, substance abuse, or conflict.

3.2. Current approaches to intervention

MacMillan et al. (2009) described a public health model for the prevention of child abuse and neglect (see Fig. 1). In it, universal approaches focus on whole populations of parents and children, e.g., the campaign to stop the physical punishment of children to prevent physical abuse (Durrant, Stewart-Tufescu, & Afifi, 2019): Targeted approaches are implemented for specific at-risk populations, e.g. vulnerable pregnant women, who may be abusing substances (Barlow, Dawe, Coe, & Harnett, 2016). Both of these approaches are intended to prevent child maltreatment occurring. Where child maltreatment has been identified, specialist interventions are intended to prevent the recurrence of maltreatment and the long-term impairment of these children and young people's health and development, including into adulthood.

There are a considerable number of interventions designed to prevent recurrence and the avoid long term impairment of children's health and development that relate to various forms of child maltreatment. Macdonald et al. (2016) identified 198 studies including 62 Randomized Control Trials (RCTs), the majority of which are for single forms of maltreatment. In the UK, NICE (National Institute for Health & Care Excellence, 2017) recommended 15 well-evidenced approaches, valuable for specific services and specific populations. A systematic review of trials to improve child outcomes associated with ACEs (Marie-Mitchell & Kostolansky, 2019) identified 20 RCTs, all focused on children under five years of age who are exposed to parents with mental health difficulties.

3.3. Limitations of these interventions in practice

Macdonald et al. (2016) comment that Trauma-Focused Cognitive Behavior Therapy is effective for post-traumatic stress disorder, complex trauma, and associated emotional problems. However, they note *"most children experience more than one form of maltreatment, and there is growing recognition of the need to better take into account children's profiles of maltreatment in order to improve policy and practice"* (p. 38). The NICE guidelines draw on differing theoretical models and concepts, presenting a considerable challenge to planners and commissioners of services who must decide which types of interventions will best address the needs of those in receipt of their services. Lester et al. (2019) note that current interventions explicitly address neither the clustering of different ACEs nor the longer-term need for support of the children and young people affected.

3.4. The challenges of developing effective interventions

Addressing the needs of individuals who have experienced polyvictimization and multiple ACEs presents a challenge to those developing effective interventions as these experiences have a cumulative harmful impact on the developing child's mental health and wellbeing. For example, caregivers who demonstrate maltreating behaviors fail to provide emotional support to their child or to consider their child's perspective, and, they discourage the expression of the child's emotions resulting in disorganized attachment responses (Bertholet, Lemieux, Garon- Bissonette, Lacharite, & Muzik, 2019; Corcoran & McNulty, 2019). Coercive family interactions,

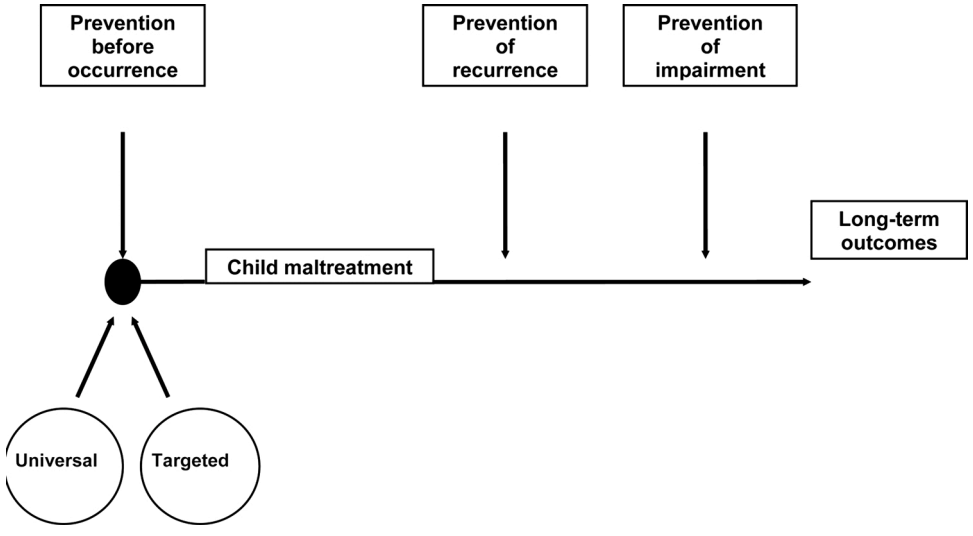

Fig. 1. Public health model for the prevention of child abuse and neglect. (Adapted from MacMillan et al., 2009).

parental stress, and conflict provide a context where children and young people's aggressive and abusive behaviors may be learned and reinforced (Asmussen, Fischer, Drayton, & McBride, 2020; Scully, McLaughlin, & Fitzgerald, 2020).

The neurobiological impact on individuals of traumatic and stressful events such as those described above results in a "*cascade of toxic stressful, inflammatory and hormonal responses with marked effects on brain morphology, function and network architecture*" (Teicher, Samson, Anderson, & Ohashi, 2016, p. 254). Complex adversity leads to clusters of symptoms and multiple different types of disorders rather than specific disorders - 'trauma-related psychopathology' (Lewis et al., 2019). A spectrum of overlapping internalizing and externalizing disorders results. The specific response depends on their interaction with other risk and protective factors (McCrory, Gerin, & Viding, 2017), and the more extensive the adversity, the greater the severity of psychiatric symptoms (Cecil, Viding, Fearon, Glaser, & McCrory, 2017). Some individuals are genetically more or less vulnerable to stressful environmental influence and show resilience in the face of highly stressful events (Bellis et al., 2018; Belsky & Hartman, 2014; Van IJzendoorn et al., 2020). The complexity of individual's responses to polyvictimization and multiple ACEs, therefore, demands a therapeutic approach that can encompass an infinite range of responses.

4. How a modular intervention approach may help

Modular approaches were developed to meet the treatment needs of children and young people with a range of mental health problems (e.g., Chorpita, Daleiden, & Weisz, 2005). A related approach to conceptualizing specific practices in the literature sought ways to capitalize on the knowledge embedded in evidence-based treatments for mental health (e.g., Chorpita & Daleiden, 2009). A structured methodology was developed to map, identify and categorise the common treatment features from 615 treatments in 322 randomized trials. It was possible to distill out the specific practice components of each type of treatment i.e. practice elements from different manuals. For example, an effective treatment for anxiety included five practice elements, namely, *Self-monitoring, Modelling, Exposure to feared items, Relaxation* and *Psychoeducation*. These could be aggregated with elements distilled or coded from other manuals. The elements which were used most frequently could be described as a common practice elements – e.g. *Exposure to Feared Items*, and *Relaxation skills*. These common practice elements could be used to inform the design of a treatment protocol informed by a large body of literature, using a modular format to represent individual procedures. Carrying out a similar distillation of common practice elements from across treatment manuals for mental health disorders establishes *a* library of modules and guides. These can be organized to meet the spectrum of overlapping mental health needs of the child and young person.

The Modular Approach for Children with Anxiety, Depression, Trauma and Conduct problems (MATCH-ADTC: Chorpita & Weisz, 2009) is a multi-disorder intervention system that incorporates treatment procedures (elements) and treatment logic (coordination) based on four successful evidence-based interventions for childhood anxiety, depression, trauma, and conduct problems, with modifications allowing the system to operate as a single protocol. The approach is highly relevant to treating the spectrum of overlapping internalizing and externalizing disorders resulting from multiple maltreatment and ACEs. The MATCH-ADTC has strong empirical support in multiple community based RCTs (e.g., Chorpita et al., 2017; Weisz et al., 2012). This approach provided the foundation for a modular approach to work with polyvictimization and multiple ACEs through the addition of interventions with the parenting and

Table 1
A description of the modular Hope for Children and Families Intervention Resources.

Guides	Description of the guides
Engagement and Goal Setting	The '*Engagement and goal setting guide'* (Bentovim et al., 2017) helps practitioners promote a sense of hopefulness, orientates the practitioner and family to the profile of child maltreatment, Adverse Childhood Experiences, family strengths and difficulties, and establishes shared goals, and the measures by which outcomes will be monitored.
Targeting the parental antecedents of maltreatment and ACEs	Four intervention guides cover different areas of parenting*: 'Promoting positive parenting'* (Roberts, 2016), '*Promoting children and young people's health, development and wellbeing'* (Bentovim, 2017a); '*Promoting attachment, attuned responsiveness and positive emotional relationships'* (Gates & Peters, 2017); and, '*Modifying abusive and neglectful parenting'* (Bentovim, 2017b). The guides' modules provide an understanding of the historical and familial stresses associated with abusive and neglectful parenting; the impact of abuse and neglect on children's health and development; interrupting and modifying abusive and neglectful processes, modifying negative perceptions of children, and improving the standard of care. They can be adapted for use with foster, adoptive, and residential caregivers.
Working with families	The '*Working with Families'* intervention guide (Jolliffe, 2016) supports practitioners in their work with families as a group, and in various combinations. This skill helps them to facilitate parent-child communication, and interrupt and find alternatives to conflict within the family, and between the parents and community.
Direct work with children and young people	Two intervention guides consider working with children and young people: '*Addressing emotional and traumatic responses'* (Weeramanthri, 2016); and, *'Addressing disruptive behaviour'* (Eldridge, 2017). These are core guides for working with children and young people who have been exposed to abusive and neglectful parenting, and contain modules included in the MATCH approach. These modules help practitioners work with parents and caregivers to develop children and young people's generic skills to manage their emotions, be safe and develop problem solving abilities. Once basic coping skills have been mastered there are modules for addressing specific anxiety, mood, traumatic responses and disruptive behaviour.
Working with child sexual abuse	The '*Working with child sexual abuse'* guide (Eldridge, 2016) considers working with children and young people who have been abused sexually, their parents/caregivers, and with those who are responsible for or who display harmful sexual behaviour. It is essential that practitioners develop skills to support children and young people who have been exposed to sexual abuse and demonstrate sexually harmful behaviour, often in association with other forms of maltreatment and adversity, and to support their parents.

family factors that trigger and maintain child maltreatment, and adversity.

5. The Hope for Children and Families Intervention Resources

Using the methodology described above for developing the MATCH-ADTC, common treatment elements were distilled from across the field of interventions for individual forms of child maltreatment. Twenty-two RCTs were identified for the treatment of different forms of maltreatment (Bentovim & Elliott, 2014). The forty-seven common practice elements that emerged were categorized as focusing on work with children, young people, parents/caregivers and the family as a whole. Elements targeting the antecedents of child maltreatment include psychoeducation for parents; exploration of the impact and origins of abuse and exposure to violence; addressing parental mental health difficulties; and, learning positive parenting skills. The elements targeting work with children and young people include psychoeducation on the impact of their maltreatment; managing and exposing traumatic thoughts and feelings; relaxation; problem-solving; relationship building; and, social skills talent/skill building.

The forty-seven common practice elements were organized into a library of modules (Bentovim & Gray, 2016; 2017). Within each module, information from theory and research provides a stepwise approach to the evidence-based intervention. In addition, scripts, guidance notes, hand-outs, and activities are provided for use by practitioners to support their delivery of these interventions.

The modules were then organized into a set of themed guides, the *Hope for Children and Families intervention guides for practitioners* (Bentovim & Gray, 2016; 2017), focusing on work with children and young people, parents/caregivers, and the family. The nine guides provide an accessible range of resources for use by practitioners working with children and families in all types of settings (see Table 1).

The structure of the guides is underpinned also by the three domains of the UK government's guidance, *The Framework for the Assessment of Children in Need and their Families* (Department of Health, Department for Education and Employment, & Home Office, 2000), namely each child's developmental needs, parental capacity to respond to these needs, and the family and environmental factors that impact on children's needs and their parents' capacities (see Fig. 2). These domains are used to structure not only assessments but also the planning and delivery of interventions with a focus on optimizing the developmental outcomes for each child.

6. Application of the Hope for Children and Families intervention resources to a specific case: The Ward Family

The HfCF approach encompasses a seven-stage process of working with children and families from the point of referral to an organization through to case closure (Bentovim, Gray, Heasman, & Pizzey, 2017; Pizzey, Bentovim, Cox, Bingley Miller, & Tapp, 2016). A summary of each stage is set out in Table 2. A composite case example (the Ward Family) is used to illustrate this process, identifying which guides might be selected for use and the type of interventions that might be undertaken when working with the children and their family.

The Ward Family (see Fig. 3) comprises Michael (aged 8 years) and Laura (aged 14 years) who live with their mother, Moira, and her new partner Ian Ross. The family have moved recently to a new area. Moira is divorced from Bill Ward, the father of the children, and there has been no contact between the children and him for many years. She had relatively recently ended a relationship with Gary Wills, with whom the children got on well, before deciding to establish a new family unit with Ian Ross.

6.1. Stage one: considering the referral and establishing assessment aims

Michael was referred to children's social care services by his school. His teachers were concerned about Michael being late for school, being hungry and isolated at school, and his neglected appearance having been smartly dressed the term before. The family were reported to have moved into the area recently after Ian Ross had joined the family following the break-up of the couple's previous relationships. They were not

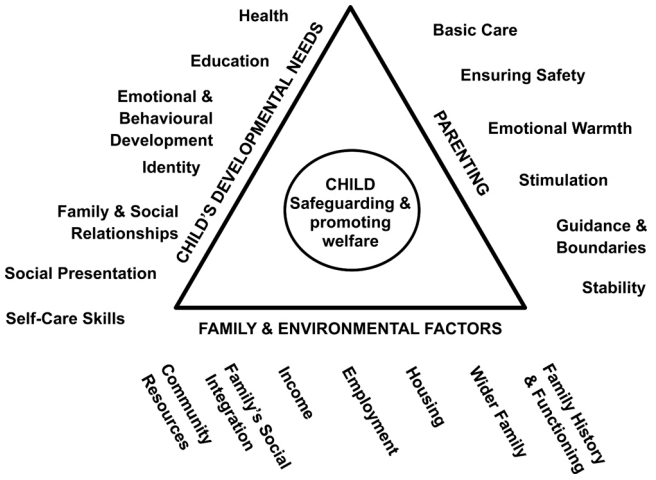

Fig. 2. The Assessment Framework (Department of Health et al., 2000).

Table 2
A seven-stage process of assessment, analysis, planning, intervention and review.

Stages of the process	Practitioner tasks for each child in a family
Stage 1	Consider the referral and the aims of the assessment
Stage 2	Gather assessment information on the child's developmental needs, parenting capacity, and family and environmental factors
Stage 3	Organise the information using the Assessment Framework and a chronology
Stage 4	Analyse the patterns of strengths and difficulties
Stage 5	Make judgements based on a systemic analysis
Stage 6	Make decisions and develop a plan of intervention
Stage 7	Implement the plan of intervention, monitor and review progress

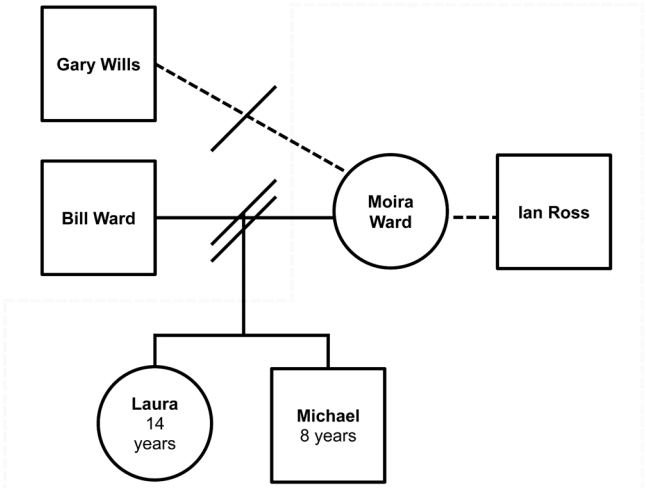

Fig. 3. Genogram of the Ward Family.

known to statutory child protective services.

6.2. Stage two: gathering assessment information on the child's developmental needs, parenting capacity and family and environmental factors

Following the referral, an initial home visit provided evidence of neglectful care. Michael's complaint that his 'stepfather' "hits him" was explained as a "tap" by his mother. Child protective services decided to undertake a full child and family assessment. This involved an assessment of Michael and of Laura's developmental needs, and Moira and Ian's capacity to meet these within the context of their family and environmental factors using the HOME Inventory (Caldwell & Bradley, 2003; Cox, Pizzey, & Walker, 2009)*; The Family Pack of Questionnaires and Scales* (Cox & Bentovim, 2000)*, and The Family Assessment* (Bentovim & Bingley Miller, 2012)*. Use of these assessment approaches provided a baseline for evaluating the effectiveness or not of the subsequent interventions developed in Stage 6 below and implemented in Stage 7 below.*

An exploration of the quality of Moira and Ian's parenting using the HOME Inventory found evidence of poor quality parental care, limited emotional and practical support, inappropriate expectations of Michael and Laura, and Michael being blamed for his failure to get himself ready for school. Use of 'The Family Pack of Questionnaires and Scales' identified that Michael might have a depressive disorder, that both Ian and Moira might be experiencing mental health difficulties (Ian's scores were elevated in terms of anxiety and outward directed irritability and Moira's scores were elevated in terms of depression, anxiety and inward directed irritability) and that Moira was experiencing a high level of parenting daily hassles. Use of 'The Family Assessment' identified conflict between Ian and Laura, Michael's distress, and that Moira was caught in the middle. Ian denied hitting the children. Laura asserted he had hit her mother, who blamed herself, but made Ian leave temporarily. Laura also raised concerns about mother's alcohol consumption getting out of control. Ian's attempts to introduce a more rigid controlling approach to discipline as opposed to Moira's 'laissez-faire' style was leading to conflict. An individual assessment with Michael confirmed his fearfulness, being smacked, and conviction he was deserving of Ian's punishment. A history of violence in Ian and Moira's past relationships, with Moira drinking alcohol as a coping strategy also emerged from individual interviews with each adult.

6.3. Stage three: organising the information using the Assessment Framework and a chronology

The information gathered during an assessment of each of the Ward family members and of the family as a unit was organized using the structure provided by the Assessment Framework, identifying strengths and difficulties in all dimensions. A chronology of salient information

gathered in the assessment was prepared to understand the relationship between impairments in Michael and Laura's respective health and development and life events and stressors which may point to connections that may be significant, for example, Ian joining the family.

6.4. Stage four: analysis the patterns of strengths and difficulties

An analysis of the strengths and difficulties for each child in the family was undertaken in Stage 4. *In the Ward family, notwithstanding identified strengths such as Moira's warm relationship with both Michael and Laura in the past, that the home was generally well kept and that Ian maintained a steady job and provided financially for the family, the ACEs score had risen from three (Family separations, Moira being treated violently and alcohol misuse) to six (with addition of emotional neglect, physical neglect, and physical abuse).*

6.5. Stage five: make judgements based on a systemic analysis

In Stage 5 a systemic analysis is completed to consider the likely outcome for each child's health and development if nothing changes (Pizzey et al., 2016). This is underpinned by an analysis of the processes influencing each child's health and development and their impact which may be positive or negative. Processes refer to the ways in which individual factors relate to others in the same or different dimensions of the Assessment Framework; the pattern of influences. This leads to identification of the patterns of concern about impairment to the child's health and development, and harm to the child. Processes that support strengths in the child's health and development are identified so that they can be supported.

The systemic analyses for Michael and Laura are set out in Figs. 4 and 5 *respectively. It is helpful to consider Michael and Laura separately as each has their own individual needs and differing relationships with their mother and with Ian. For Michael, the systematic analysis demonstrated that he is at risk of increasing withdrawal and depression, physical harm and neglect. There is an affectionate relationship between Moira and Michael which needs supporting and maintaining. The systematic analysis regarding Laura identified she is more resilient, but she would be at risk of increasing emotional distress, engaging in conflictual arguments with her mother and Ian, and risky* behavior *outside the home. Systemic analyses of the information gathered during the assessment showed that for both children the nature of the risk factors and processes out-weighed the protective factors and processes, and without effective intervention the prognosis would be doubtful, and further harm to Michael and Laura is likely. To achieve a favourable outcome for each of the children changes in the dominant negative processes will need to be achieved. Ian will need to acknowledge the harmful impact of his expectations of Michael and of Laura, and his harsh parenting* behavior *and his use of violent means to control them which have been influenced by his childhood experiences. Moira will need to understand her long-standing pattern of drinking in the face of conflict and stress and accept help to control it. They will both need to accept a systemic intervention, including a child-focused component.*

Upon completion of the systemic analysis, an analysis of the likely response to intervention (the prospects for change) is undertaken. This requires an understanding of the factors and processes associated with parental child-centredness (i.e. the capacity of Ian

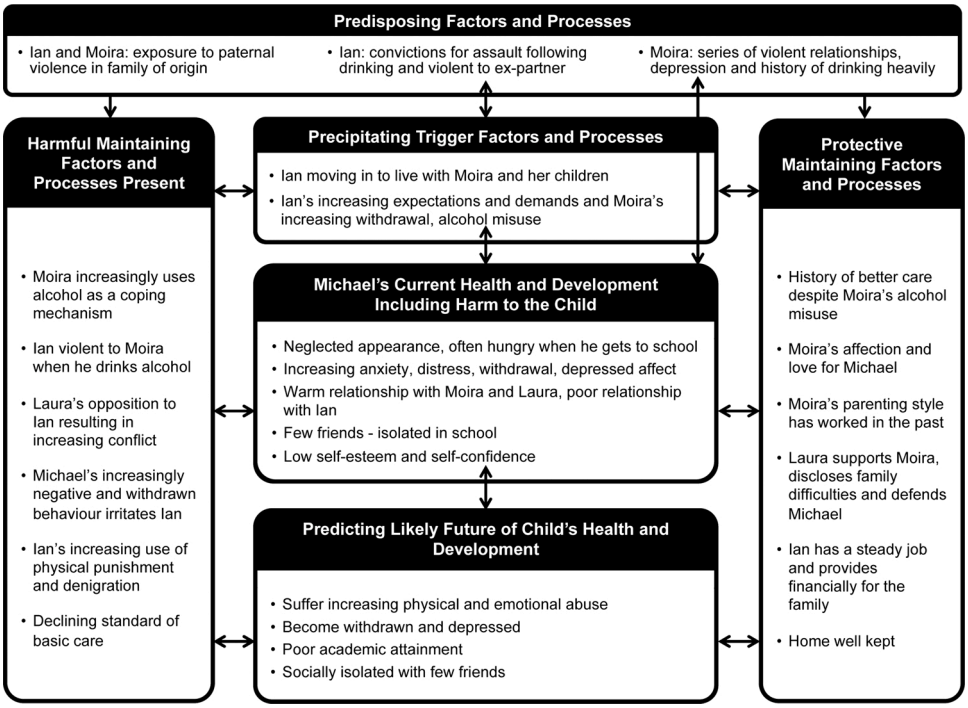

Fig. 4. Michael Ward: Systemic Analysis.

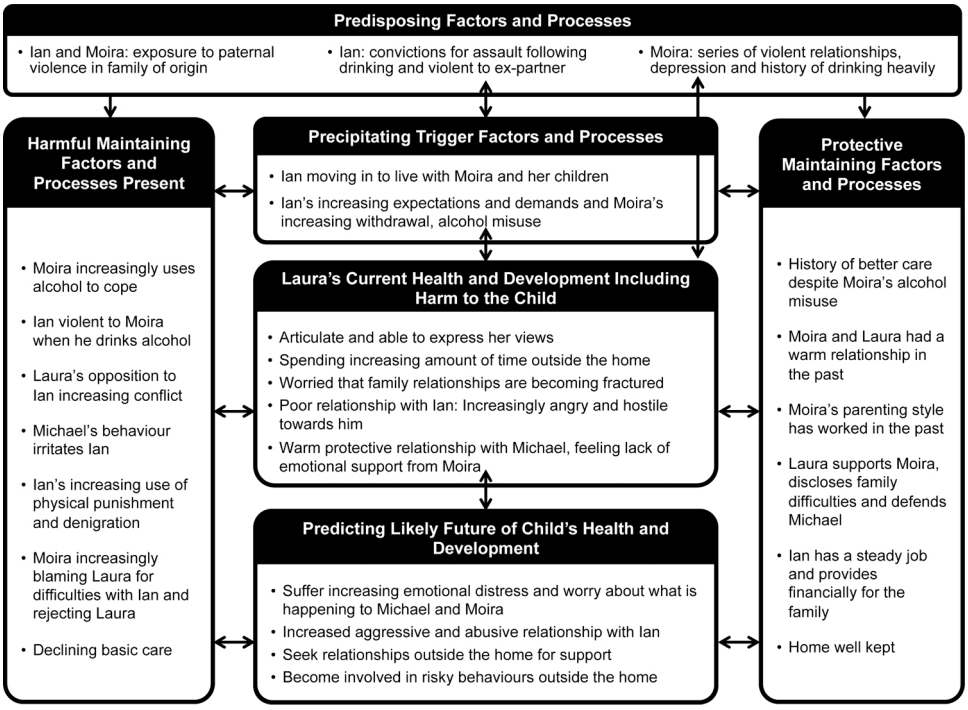

Fig. 5. Laura Ward: Systemic Analysis.

and Moira to recognize, understand, acknowledge and take responsibility for difficulties) and their level of modifiability (i.e. their level of motivation and capacity for change and their readiness and ability to cooperate with professionals and agencies). *Notwithstanding the difficulties set out above Ian and Moira were committed to remaining together, Ian was committed to continuing to provide financially for the family, warmth was observed between Moira and Michael, and Laura was able to assert her needs and draw attention to Michael and Moira's distress. The likely response to intervention was uncertain but there were sufficient grounds for testing whether the implementation of an intervention plan could bring about positive change.*

6.6. Stage six: make decisions and develop a plan of intervention

Findings from the systemic analysis are used to make decisions about the content of the intervention plan. This involves deciding which modules from which guide will be used to achieve the planned outcomes for each child and the sequence in which to undertake these. Descriptions of the nature of the work to be undertaken using each guide with the Ward Family (with the exception of the one on Child Sexual Abuse as this form of harm was not present in this case) are set out below. The decision making process is customized for each child and their family, with the planned program of work addressing each of their needs in a co-ordinated manner that makes sense to the family and is practicable to implement.

When planning therapeutic interventions, it is helpful to consider the following four phases: (1) An initial stage setting goals and making a protection and treatment plan, (2) In a context of a family separation, undertaking work on parenting (with and without the children present), (3) undertaking individual work with the children, and (4) contemplating and testing the possibility of successful family rehabilitation.

6.6.1. Phase 1: engaging with family members and setting goals together to develop a child protection and treatment plan

The 'Engagement and goal setting intervention guide for practitioners' (Bentovim et al., 2017) establishes a profile for intervention, goal setting, intervening and measuring progress. *It can be used by the practitioner in their work with the Ward Family to help them focus on how to engage with Michael and Laura as individuals, with Moira and Ian and with the family for the purposes of promoting hopefulness, and establishing family safety and management plans and a non-violence agreement. Work can then be undertaken to establish collaborative goals with the family members, including agreeing the criteria for Michael and Laura respectively to be able to live safely at home. This would include the need to address Ian's harsh parenting* behavior *and his use of violent means of control affecting Michael and Laura; Moira's escalating alcohol misuse, which has resulted in her neglect of Michael; and, Laura feeling a lack of emotional support from her mother.*

6.6.2. Phase two: work with parents to provide better quality care and positive parenting

The overall goal is to help promote children's recovery and resilience. A range of guides can be used to help parents, individually, or jointly. Children and young people can be included particularly when rehabilitation is being considered.

Modules within the 'Modifying abusive and neglectful parenting' guide (Bentovim, 2017b) *can be used to help Ian and Moira understand how their abusive and neglectful parenting affects Michael and Laura's emotional and physical development. They can also be used to help Moira and Ian take responsibility for the harmful impact on Michael and Laura's development as a consequence of their exposure to violence, harsh parenting, inappropriate expectations and parental alcohol misuse. Modules in this guide can be used to help Moira and Ian explore how their stress arises and understand how it affects their behaviour, attachment responses, and capacities to provide good quality care for Laura and Michael. The modules can then help them manage the sources of the stressful life events that have triggered their harsh discipline, violence, and growing alcohol misuse, by introducing them to appropriate coping strategies. Interventions will focus on finding alternatives to harsh parenting by introducing Moira and Ian to positive parenting approaches from the 'Promoting positive parenting' guide* (Roberts, 2016)*, enabling them to create a safe environment for the children, apologizing to them about the harm suffered and reconciling with them before planning a protective, stable and nurturing future.*

The use of the 'Promoting positive parenting' guide can also help Ian and Moira appreciate the complex origins of Laura's challenging behavior *and the value of praise and positive attention. Moira and Ian will be introduced to the use of appropriate rewards and effective guidance for both Laura and Michael.*

The 'Promoting children and young people's health, development and wellbeing' guide (Bentovim, 2017a) *can be used to help Moira and Ian identify and understand Michael and Laura's respective physical and emotional developmental needs, what parental care is age appropriate, and ensure the children's education is supported. The focus will be on how they can provide good quality care, working in particular with Moira to establish good quality care and nutrition through establishing goals and collaborative approaches to achieving them.*

The 'Promoting attachment, attuned responsiveness and positive emotional relationships' guide (Gates & Peters, 2017) *can be used to build positive relationships within the family. The focus will be on helping Moira and Ian understand Michael and Laura's respective attachment responses and needs, and on promoting positive emotional responses through use of one-on-one time, particularly between Ian and Michael, and Moira and Laura.*

6.6.3. Phase three: undertaking individual work with the children

The guide 'Working with children and young people: Addressing emotional and traumatic responses' (Weeramanthri, 2016) *can be used when undertaking individual work with Michael and with Laura within a positive therapeutic emotional environment. They will each be helped to develop a toolkit of generic skills, to understand the impact on them of maltreatment and exposure to violence, reduce their self-blame and devise a safety plan. Michael and Laura will be enabled to develop their coping skills, relaxing and calming techniques, activities to improve their social skills and peer relationships, and have a positive effect on their mood as well as problem solving skills.*

Michael will be helped to develop a trauma narrative of the direct harmful experiences he has suffered and those he has witnessed and to process these experiences. He will also be helped to cope with avoidance and traumatic memories, to develop sleep routines and a sense of mastery, recovery and resilience. Laura is more resilient, and her response to family conflict has been to distance herself, continue to attend school, and receive peer support. She is confronting and argumentative in her style and has had the strength to be able to draw attention to her mother's drinking. She will be helped by developing generic coping skills, and to construct her own narrative of events and understand the link with her challenging angry responses.

6.6.4. Phase four: contemplating and testing the possibility of successful family rehabilitation

When working with the Ward family, the interventions will focus on promoting healthy family functioning through facilitating family communication. The objectives will be to develop effective approaches to manage conflict and dysfunction within the family, interrupt the conflict cycles between Ian and Moira, Michael and Laura and test out the their newly acquired positive parenting and relationship skills, and create a context for acceptance and a safe future for the children.

The 'Managing abusive and neglectful parenting' guide includes a module to support work with parents to establish the importance of them apologizing to their children about the harm suffered and reconciling with them before planning a protective, stable and nurturing future.

The sexual abuse guide was not used with the Ward family, as no sexual abuse was identified or disclosed.

6.7. Stage seven: implement the plan of intervention, monitor and review progress

In working with children and families it important to monitor the intervention and review progress towards achieving the intervention goals and whether the child's developmental needs are being met. This involves repeating baseline measures used before the interventions were commenced and developing case-specific measures which can be replicated over time. *Changes in Michael and Laura's health and development can be evidenced by observations of their relationships with different family members, repeating use of questionnaires and scales in 'The Family Pack of Questionnaires and Scales' to evaluate their mental health and traumatic responses, and through school reports. For Michael, the expected outcomes would be that he is protected from physical abuse and inappropriate punitiveness, and that the quality of care provided by Moira and Ian is more satisfactory as is his growth trajectory. Also, that his attendance at school is regular, relationships with his peers have improved, he is less anxious and withdrawn, his confidence is restored, his traumatic responses have been resolved, his attachments to his mother restored, and a positive relationship is beginning to be established with Ian. For Laura, the expected outcomes would be that she is not experiencing emotional distress, feels safe and enjoys being in her own home, and is experiencing a warm, supportive relationship with Moira and a less oppositional relationship with Ian.*

Changes in parenting and family life can be evidenced by repeating 'The HOME Inventory'. *Expected outcomes would be that Laura and Michael are experiencing better quality care, Michael's nutrition is satisfactory and family relationships are improved. Moira and Ian are communicating well and working together. They have created a safe family environment with appropriate expectations and supervision of the*

children. Moira and Ian are demonstrating responsiveness to each child's developmental needs, consistent management of their behavior, *offering praise and providing appropriate boundaries and rules.*

Individual and family assessments can be repeated to establish if there has been a change in both individual and family functioning. *Expected outcomes would be that the individual functioning of Moira and Ian respectively shows positive change, they provide mutual support to each other rather than violence, and Moira no longer uses alcohol as a coping mechanism.*

7. Results from piloting and initial implementation programs

Extensive evaluations of the modular approach (MATCH-ADTC) have included community research with young people presenting with mental health problems. Weisz et al. (2012) and Chorpita et al. (2013) demonstrate that practitioners trained in the modular approach were more effective than those providing usual care, and were more effective compared with practitioners trained in the individual treatment manuals which formed the basis of the MATCH-ADTC. A subsequent trial included a number of children and young people whose most important problems included 'traumatic stress'. The MATCH approach again out-performed a community-implemented, evidence-based treatment comparison group (Chorpita et al., 2017).

A pilot of the modular *Hope for Children and Families Intervention Resources* was undertaken in England to investigate whether the MATCH approach would be as effective when used in the child maltreatment field. Front-line practitioners and their managers/supervisors were offered cohort training in five sites. These comprised four local authorities and one independent children's services organization undertaking a range of work from early intervention through to child protection and children in state care (foster and residential). It also included staff working with young people in the juvenile justice system. The participants were from a variety of disciplines (social work, psychology and psychiatry): some had relevant professional qualifications, others did not (Gray, 2015).

Forty-nine day workshops were delivered across the pilot sites to assist practitioners, their first line managers and practice consultants in understanding the HfCF approach and how to use the intervention resources. They covered the practice themes within the intervention resources focusing on engagement and goal setting; working with children; working with parents/caregivers and working with families. In addition, a series of coaching/supervision sessions were offered regularly (every two or four weeks depending on agency requests) to first line managers and pilot site supervisors/ practice consultants in each of the pilot areas to enable them to support practitioners to use the intervention resources effectively.

Child and Family Training, the training providers, administered its own evaluation forms comprising a Confidence Scale and a Workshop evaluation. The Confidence Scale is administered at the start and the end of each training event. It is structured according to the learning outcomes of each workshop and uses a six-point Likert scale for participants to rate their confidence before and after the training workshop. The Confidence Scale evaluates whether participants feel more confident by the end of the training program in the areas covered by the learning outcomes. The workshop evaluation form is administered at the end of each training event. It relates to the learning objectives, relevance and usability of the intervention resources that were the subject of the event, Results from the confidence scale and workshop evaluation are compiled into a report which is sent to the commissioning agency prior to the next training course. Any issues arising are dealt with promptly.

A total of 578 completed evaluation forms were received from all five pilot sites. The majority of responses either 'strongly agreed' or 'agreed' with the evaluation statements about the value of the training. Course participants emphasized the value of the new knowledge and skills in working with children and their families they had gained from the training. Practitioners were more confident generally in their abilities and competence particularly working with trauma, helping parents understand effects of abuse and neglect, meeting children's safety and physical needs and understanding children's development in general, and working with families (Gray, 2015).

Subsequent programs of training for Newly Qualified Social Workers (Roberts, 2017) and Early Years Family Support Workers (Pizzey & Bisdounis, 2020) in two different agencies were undertaken on guides selected as relevant to their roles and responsibilities. The programs were evaluated using a Confidence scale based on the learning outcomes of each course, a Workshop evaluation, and the *Self-efficacy scale for social workers* (SSESW: Pedrazza, Trifiletti, Berlanda, & Di Bernardo, 2013) which reflects practitioners' judgements about their capacity to exercise influence in specific situations and to achieve successful outcomes. The workshops and associated coaching helped each practitioner construct and undertake assessments, analysis, and plan and implement interventions that respond to the specific needs of the children and families with whom they were working. These families included children who have suffered complex, multi-type maltreatment. Responses to the program's evaluation questionnaires and direct feedback from the practitioners being trained demonstrated that they had benefited from these training programs and considered they had improved their skills, knowledge and confidence.

The program of training for Newly Qualified Social Workers (Roberts, 2017) was also evaluated using the Quality of assessment questionnaire (Roberts, Cox, & Bingley Miller, 2016). There were statistically significant changes in practitioners' ability to carry out good quality assessments. Improvements were seen in gathering information, organizing the gathered information, analysis, planning interventions and measuring outcomes.

The pilots and subsequent training programs have demonstrated that successful implementation of the HfCF Intervention resources require sustained Internal and external organizational support, including involvement of senior managers. The components of a successful implementation included: attendance at thematic workshops followed by the provision of good reflective supervision of the trained practitioners (the HfCF resources reinforce good practice but do not replace it); clinical/practice supervision groups receiving 2–4 weekly input from a specialist clinician acting as a 'champion'; support for line managers; and, offering continuing professional development opportunities that enable participants to build on their learning.

8. Discussion of strengths and limitations

8.1. Strengths

The HfCF program demonstrates the development of an effective modular approach (MATCH-ADTC). The pilot and subsequent implementation of the program have demonstrated that the *HfCF Intervention guides for practitioners* could provide effective resources for use within different types of children's services provision (e.g. social care/child protection, health, education and youth justice services), and at all stages of the therapeutic process from intervening early and targeting vulnerable families, to responding to identified maltreatment and working with children placed in foster care, residential or adoptive placements. The HfCF resources could provide the tools to deliver effective Trauma Informed Practice, an approach which includes a variety of components to address the impact on children's health and behavior of multiple ACEs across different agencies in the community (NHS Highlands, 2018; Pachter, Lieberman, Bloom, & Fein, 2017).

There is equal emphasis in the HfCF on modifying antecedents, interrupting processes that maintain adversity, supporting resilience assets, and promoting social relationships, new lives, and activities that develop each child's coping capacities and friendship and social supports. Practitioners from a variety of services, including those who have experience but no formal professional training, have recently qualified, or are highly qualified, have all found the resources valuable. The guides provide detailed information and guidance for practitioners working with particular populations, e.g. in Early Intervention Teams, and for experienced practitioners intervening across a wide range of complex presentations of child maltreatment.

8.2. Limitations

Modular approaches have proven effective in RCTs for children and young people with overlapping mental health disorders and have proven valuable to practitioners working with child maltreatment. However, the effectiveness of the HfCF has not been tested for polyvictimization and multiple ACEs through a RCT. A possible research method is that used in the controlled evaluation of a 'Triple P' Positive Parenting Programme undertaken in a whole community by Prinz, Sanders, Shapiro, Whitaker, and Lutzker (2009). The goal would be to assess whether the HfCF resources could provide effective tools for use by practitioners working with children, young people and their families in the community.

The manuals, constructed from common practice elements, could not include specialized approaches for significant mental health difficulties in the child or young person outside of the established range of responses to maltreatment and adversity, e.g. significant neurobiological syndromes or associated psychotic states. Collaboration with a child and adolescent mental health team would be essential when working with a child or young person who has significant mental health difficulties.

There is scope to design manuals for specialized populations (Shafran et al., 2020). Although extensive parenting approaches are included in the HfCF resources, parents with significant mental health, interpersonal violence or substance abuse difficulties would require a collaborative approach working with relevant adult services in the community.

9. Conclusion

The modular approach which can incorporate common practice elements from across the field of relevant interventions has the potential to play a key role in the mission to break the circle of maltreatment and adversity. The possible effectiveness of the approach is an example of what has been referred to generally as using 'evidence to guide practice' (e.g., Graham et al., 2006). We believe our field is on the verge of a revolution in how we make science actionable to realize the mission of mental health and wellness worldwide (e.g., Chorpita, 2019). The mission needs to be extended to preventing the life-long harmful sequelae in the face of polyvictimization and multiple ACEs. Internationally, this approach could provide a key building block to transforming and integrating the work of practitioners from various disciplines in countries with varying income levels marking an important milestone at the 30th Anniversary of the UN Commission on Human Rights, 1990*United Nations Convention on the Rights of the Child* (1990) and on the journey to end all forms of violence to children by 2030 (United Nations, 2015).

Acknowledgements

The authors acknowledge the valuable suggestions of the reviewers on the initial draft of the paper. The development of this work was funded by Child and Family Training (CFT) UK, a not for profit organization. CFT, the Lucy Faithfull Foundation and the Michael Sieff Foundation organized and funded a national conference *Eradicating Child Maltreatment: Intervening with Children and Families; Policy and Practice* in 2012 to consider the modular approach with international colleagues. A grant from the Department for Education, UK, in 2013-2015 funded initial piloting of the intervention resources. We gratefully acknowledge the contributions of Professor Rachel Calam, University of Manchester, and Professor Roz Shafran, Institute of Child Health, UCL to this text. We also gratefully acknowledge the contributions of the many colleagues who helped create this valuable set of intervention guides, and who helped demonstrate their value.

References

Asmussen, K., Fischer, F., Drayton, E., & McBride, T. (2020). *Adverse Childhood Experiences. What we know, what we don't know, and what should happen next*. London: Early Intervention Foundation.

Barlow, J., Dawe, S., Coe, C., & Harnett, P. (2016). An evidence-based, pre-birth assessment pathway for vulnerable pregnant women. *British Journal of Social Work, 46* (4), 960–973.

Baglivio, M. T., Epps, N., Swartz, K., Huq, M. S., Sheer, A., & Hardt, N. S. (2014). The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders. *Journal of Juvenile Justice, 3*(2), 1–23.

Bellis, M. A., Hughes, K., Ford, K., Hardcastle, K. A., Sharp, C. A., Wood, S., … Davies, A. (2018). Adverse childhood experiences and sources of childhood resilience: A retrospective study of their combined relationships with child health and educational attendance. *BMC Public Health, 18*, 792.

Bellis, M. A., Hughes, K., Ford, K., Rodriguez, G. M., Sethi, D., & Passmore, J. (2019). Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America; a systematic review and meta-analysis. *The Lancet Public Health, 4*(10), e517–528. https://doi.org/10.1016/S2468-2667(19)30145-8.

Belsky, J., & Hartman, S. (2014). Gene-environment interaction in evolutionary perspective: Differential susceptibility to environmental influences. *World Psychiatry, 13*, 87–89.

Bentovim, A. (2017a). Promoting children and young people's health, development and wellbeing. In A. Bentovim, & J. Gray (Eds.), *Hope for Children and Families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Bentovim, A. (2017b). Modifying abusive and neglectful parenting. In A. Bentovim, & J. Gray (Eds.), *Hope for Children and Families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Bentovim, A., & Bingley Miller, L. (2012). *The Family Assessment: Assessment of family competence, strengths and difficulties*. York, UK: Child and Family Training.

Bentovim, A., & Elliott, I. (2014). Targeting abusive parenting and the associated impairment of children. *Journal of Clinical Child & Adolescent Psychology, 74*, 482–488.

Bentovim, A., Gray, J., Heasman, P., & Pizzey, S. (2017). Engagement and goal setting. In A. Bentovim, & J. Gray (Eds.), *Hope for Children and Families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Bentovim, A., Vizard, E., & Gray, J. (2018). Editorial perspective: Treatment of complex maltreatment - beyond the NICE guideline? Manuals, muddles or modules. *Child and Adolescent Mental Health, 23*, 297–300. https://doi.org/10.1111/camh.12280.

Bentovim, A., & Gray, J. (Eds.). (2016; 2017). *Hope for children and families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Bertholet, N., Lemieux, R., Garon- Bissonette, J., Lacharite, C., & Muzik, M. (2019). The protective role of mentalizing: Reflective functioning as a mediator between child maltreatment and parental attitude in expecting parents. *Child Abuse and Neglect, 95*, Article 104065.

Caldwell, B. M., & Bradley, R. H. (2003). *HOME inventory: Administration manual comprehensive edition*. Little Rock, AR: University of Arkansas for Medical Sciences.

Cecil, C. A. M., Viding, E., Fearon, P., Glaser, D., & McCrory, E. J. (2017). Disentangling the mental health of childhood abuse and neglect. *Child Abuse and Neglect, 63*, 106–119.

Chorpita, B. F. (2019). Increasing the world's therapeutic intelligence through strategic alignment of individuals, institutions, and industries. In *Presidential address Presented at the 53rd annual convention of the association for behavioral and cognitive therapies (ABCT)*. Retrieved from PracticeWise, Mar, 2020, Retrieved from PracticeWise, March 2020.

Chorpita, B. F., & Daleiden, E. L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology, 77*(3), 566–579.

Chorpita, B. F., & Weisz, J. R. (2009). *Modular approach to children with anxiety, depression, trauma and conduct Match-ADTC*. Satellite Beach FL: PracticeWise LCC.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research, 7*, 5–20. https://doi.org/10.1007/s11020-005-1962-6.

Chorpita, B. F., Daleiden, E. L., Park, A. L., Ward, A. M., Levy, M. C., Cromley, T., … Krull, J. L. (2017). Child STEPs in California: A cluster randomized effectiveness trial comparing modular treatment with community implemented treatment for youth with anxiety, depression, conduct problems, or traumatic stress. *Journal of Consulting and Clinical Psychology, 85*(1), 13–25. https://doi.org/10.1037/ccp0000133.

Chorpita, B. F., Weisz, J. R., Daleiden, E. L., Schoenwald, S. K., Palinkas, L. A., Miranda, J., … the Research Network on Youth Mental Health. (2013). Long-term outcomes for the Child STEPs randomized effectiveness trial: A comparison of modular and standard treatment designs with usual care. *Journal of Consulting and Clinical Psychology, 81*, 999-109.

Corcoran, M., & McNulty, M. (2019). Examining the role of attachment in the relationship between adversity, psychological distress and subjective well-being. *Child Abuse and Neglect, 76*, 297–309.

Cox, A., & Bentovim, A. (2000). *The Family Pack of Questionnaires and Scales*. London: The Stationery Office.

Cox, A., Pizzey, S., & Walker, S. (2009). *The HOME inventory: A guide for practitioners – The UK approach*. York, UK: Child and Family Training.

Craig, J. M., Piquero, A. R., Farrington, D. P., & Ttofi, M. M. (2017). A little early risk goes a long bad way: Adverse childhood experiences and life-course offending in the Cambridge study. *Journal of Criminal Justice, 53*, 34–45.

Debowska, A., Willmott, D., Boduszek, & Jones, A. D. (2017). What do we know about child abuse and neglect patterns of co-occurrence. A systematic review of profiling studies and recommendations for future research. *Child Abuse and Neglect, 70*, 100–111.

Department of Health, Department for Education and Employment, & Home Office. (2000). *The framework for the assessment of children in need and their families*. London, UK: The Stationery Office.

Durrant, J. E., Stewart-Tufescu, A., & Afifi, T. O. (2019). Recognizing the child's right to protection from physical violence: An update on progress and a call to action [published online ahead of print, 2019 Nov 30]. *Child Abuse & Neglect.* , Article 104297. https://doi.org/10.1016/j.chiabu.2019.104297.

Eldridge, H. (2016). Working with child sexual abuse. In A. Bentovim, & J. Gray (Eds.), *Hope for Children and Families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Eldridge, H. (2017). Working with children and young people: Addressing disruptive behaviour. In A. Bentovim, & J. Gray (Eds.), *Hope for Children and Families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Ellis, W. R., & Deitz, W. H. (2017). A new framework for addressing adverse childhood and community experience: The building community resilience model. *Academic Pediatrics, 17*(7S), S86–S93.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventative Medicine, 14*(4), 245–258.

Finkelhor, D., Omrod, R. K., & Turner, H. A. (2007). Poly-victimisation: A neglected component in child victimization. *Child Abuse and Neglect, 31*, 7–26.

Finkelhor, D., Shattuck, A., Turner, H. A., & Hamby, S. L. (2012). Improving the adverse childhood experiences study scale. *American Journal of Preventative Medicine, 167*, 70–75.

Flaherty, E. G., Thompson, R., Dubowitz, H., Harvey, E. M., English, D. J., Everson, M., … Runyan, D. K. (2013). Adverse childhood experiences and child health in early adolescence. *JAMA Pediatrics, 167*(7), 622–629.

Garcia, A. R., Gupta, M., Greeson, J. K. P., Thompson, A., & DeNard, C. (2017). Adverse childhood experiences among youth reported to child welfare: Results from the national survey of child and adolescent wellbeing. *Child Abuse and Neglect, 70*, 292–302.

Gates, C., & Peters, J. (2017). Promoting attachment, attuned responsiveness and positive emotional relationships. In A. Bentovim, & J. Gray (Eds.), *Hope for Children and Families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Graham, I., Logan, J., Harrison, M., Straus, S., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in translation: Time for a map? *The Journal of Continuing Education in the Health Professions, 26*, 13–24.

Gray, J. (2015). *Hope for Children and Families intervention resources pilot project: Report submitted to the Department for Education*. York, UK: Child & Family Training.

Herrenkohl, R. C., & Herrenkohl, T. I. (2009). Assessing a child's experience of multiple maltreatment types: Some unfinished business. *Journal of Family Violence, 24*, 485–496.

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., … Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health, 2*, 356–366.

Jolliffe, C. (2016). Working with families. In A. Bentovim, & J. Gray (Eds.), *Hope for Children and Families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Lacey, R., & Minnis, H. (2019). Practitioner Review: Twenty years of research with adverse childhood experience scores – Advantages, disadvantages and applications to practice. *Journal of Child Psychology and Psychiatry, 61*(2), 116–130. https://doi.org/10.1111/jcpp.13135.

Lester, S., Lorenc, T., Sutcliffe, K., Khatwa, M., Stansfield, C., Sowden, A., & Thomas, J. (2019). *What helps to support people affected by adverse childhood experiences? A review of evidence*. London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London.

Lewis, S. J., Arseneault, L., Caspi, A., Fisher, H. L., Mathews, T., Moffitt, T., & Danese, A. (2019). The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. *The Lancet Psychiatry, 6*, 247–256.

Macdonald, G., Livingstone, N., Hanratty, J., McCartan, C., Cotmore, R., Cary, M., & Churchill, R. (2016). The effectiveness, acceptability and cost-effectiveness of psychosocial interventions for maltreated children and adolescents: An evidence synthesis. *Health Technology Assessment, 20*(69), 1–508.

MacMillan, H. L., Wathen, M., Barlow, J., Fergusson, D., Leventhal, J., & Taussig, H. (2009). Intervention to prevent child maltreatment and associated impairment. *Lancet, 373*, 250–266.

Marie-Mitchell, A., & Kostolansky, R. (2019). A systematic review of trials to improve child outcomes associated with adverse childhood experiences. *American Journal of Preventive Medicine, 56*(5), 756–764. https://doi.org/10.1016/j.amepre.2018.11.030.

McCrory, E., Gerin, M. I., & Viding, E. (2017). Child maltreatment. Latent vulnerability, and the shift to preventative psychiatry – The contribution of functional brain imaging. *Journal of Child Psychology and Psychiatry, 58*, 338–357.

McLaughlin, K. A., Sheridan, M. A., & Lambert, H. K. (2014). Childhood adversity and neural development: Deprivation and threat as distinct dimensions of early experience. *Neuroscience and Biobehavioral Reviews, 47*, 578–591.

National Institute for Health and Care Excellence. (2017). *NICE guideline. Child abuse and neglect*. London: Author.

NHS Highlands. (2018). *Adverse childhood experiences, resilience and trauma informed care: A public health approach to understanding and responding to adversity*. Available from: https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH-Annual-Report-2018_.

Pachter, L., Lieberman, L., Bloom, S., & Fein, J. A. (2017). Developing a community-wide initiative to address childhood adversity and toxic stress: A case study of the Philadelphia ACE task force. *Academic Pediatrics, 17*(7), S130–S135.

Pedrazza, M., Trifiletti, E., Berlanda, S., & Di Bernardo, G. A. (2013). Self-efficacy in social work: Development and initial validation of the self-efficacy scale for social workers. *Social Sciences, 2*, 191–207. https://doi.org/10.3390/socsci2030191.

Pizzey, S., & Bisdounis, L. (2020). *Training Early Years Family Support Workers Evaluation of a training and coaching programme in direct work with children and families*. York: Child and Family Training.

Pizzey, S., Bentovim, A., Cox, A., Bingley Miller, L., & Tapp, S. (2016). *The safeguarding children assessment and analysis framework*. York, UK: Child and Family Training.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of maltreatment. *Prevention Science, 10*, 1–12.

Roberts, R. (2016). Promoting positive parenting. In A. Bentovim, & J. Gray (Eds.), *Hope for Children and Families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Roberts, R. (2017). *Training newly qualified social workers: Evaluation of a training and coaching programme*. York, UK: Child and Family Training.

Roberts, R., Cox, A., & Bingley Miller, L. (2016). *The quality of assessment questionnaire*. York, UK: Child and Family Training.

Scully, C., McLaughlin, J., & Fitzgerald, A. (2020). The relationship between adverse childhood experiences, family functioning and mental health problems among children and adolescents: A systematic review. *Journal of Family Therapy, 42*, 291–316.

Shafran, R., Bennett, S., Coughtrey, A., Welch, A., walji, F., Cross, H., … Moss-Morris, R. (2020). Optimising evidence-based psychological treatment for the mental health needs of children with epilepsy: Principles and methods. *Clinical Child and Family Psychology Review, 23*(2), 284–295. https://doi.org/10.1007/s10567-019-00310-3.

Teicher, M. H., Samson, J. A., Anderson, C. M., & Ohashi, K. (2016). The effects of childhood maltreatment on brain structure, function and connectivity. *Nature Reviews Neuroscience, 17*, 652–666. https://doi.org/10.1038/nrn.2016.111.

Thompson, R., Litrownik, A. J., Isbell, P., Everson, M. D., English, D. J., Dubowitz, H., … Flaherty, E. G. (2012). Adverse experiences and suicidal ideation in adolescence: Exploring the link using the LONGSCAN samples. *Psychology of Violence, 2*(2), 211–225. https://doi.org/10.1037/a0027107.

UN Commission on Human Rights. (1990). *Convention on the rights of the child*, 7 March E/CN.4/RES/1990/74, Retrieved from: https://www.refworld.org/docid/3b00f03d30.html [Accessed 10 May 2020].

United Nations. (2015). *Transforming our world: The 2030 agenda for sustainable development. A/RES/70/1*. Retrieved from. New York: Author https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf.

Van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Coughlan, B., & Reijman, S. (2020). Umbrella synthesis of meta-analyses on child maltreatment antecedents and interventions: Differential susceptibility perspective on risk and resilience. *Journal of Child Psychology and Psychiatry, 61*(3), 272–290.

Villodas, M. T., Cromer, K. D., Moses, J. O., Litrownik, A. J., Newton, R. R., & Davis, I. P. (2016). Unstable child welfare placements, early physical and mental health, role of adverse childhood experiences and PTSD. *Child Abuse and Neglect, 62*, 76–88. https://doi.org/10.1016/j.chiabu.2016.10.014.

Weeramanthri, T. (2016). Working with children and young people: Addressing emotional and traumatic responses. In A. Bentovim, & J. Gray (Eds.), *Hope for Children and Families: Building on strengths, overcoming difficulties*. York, UK: Child and Family Training.

Weisz, J. R., Chorpita, B. F., Palinkas, L. A., Schoenwald, S. K., Miranda, J., Bearman, S. K., … the Research Network on Youth Mental Health. (2012). Testing standard and modular designs for psychotherapy with youth depression, anxiety, and conduct problems: A randomized effectiveness trial. *Archives of General Psychiatry, 69*, 274-228.