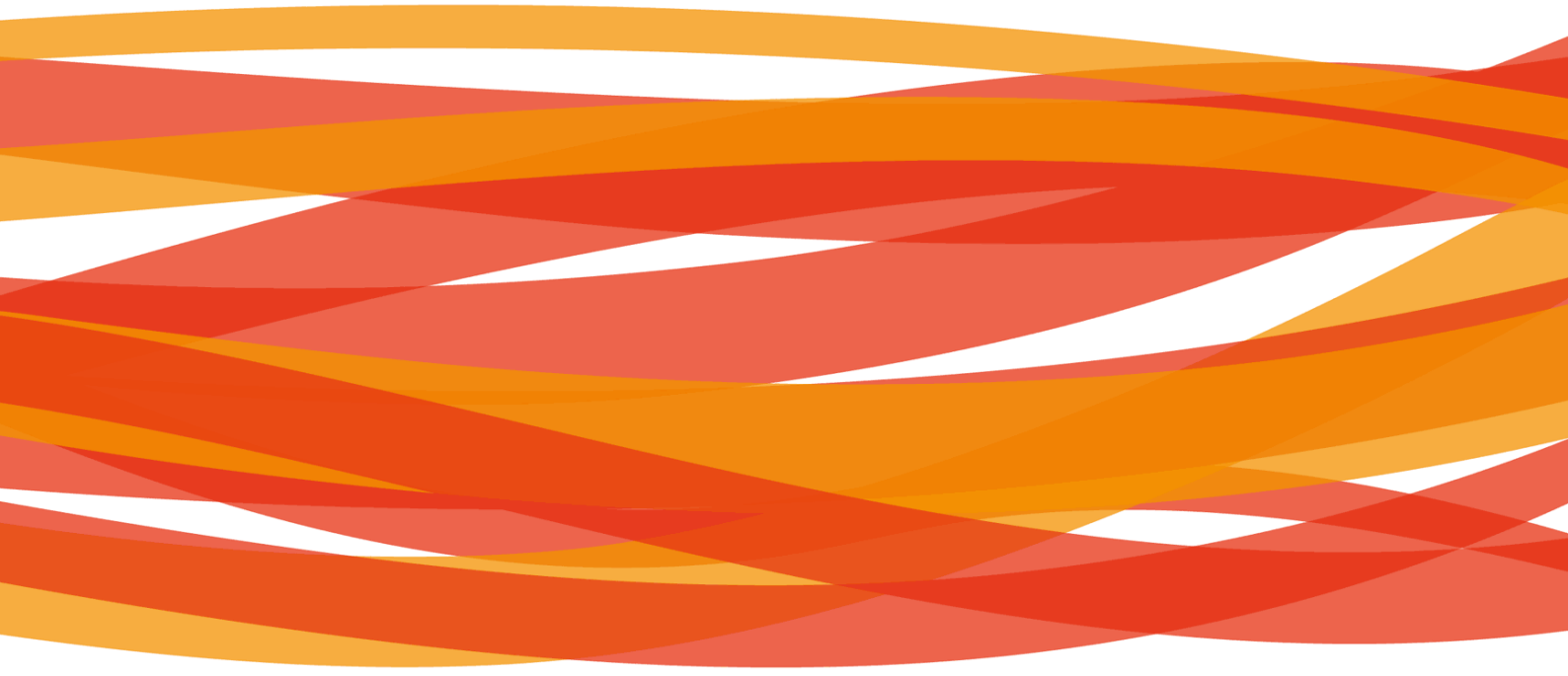
child and family training

# Therapeutic interventions to reduce the harmful effects of Adverse Childhood Experiences – ACE's –

## A modular trans- diagnostic, trauma-informed approach

An introductory guide for practitioners and managers

Dr Arnon Bentovim, Jenny Gray and Stephen Pizzey



# Therapeutic interventions to reduce the harmful effects of Adverse Childhood Experiences – ACE's – a modular transdiagnostic, trauma-informed approach

A guide for practitioners and managers

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# 1.0 Hope for Children and Families Programme

Child and Family Training (C&FT) is a not-for-profit skills development and training organisation. It developed the ***Hope for Children and Families*** (HfCF) approach that aims to enhance effective work to promote the health, development and well-being of children, young people and families through building on strengths and overcoming difficulties using evidence-based resources. The development and production of practice resources (tools, instruments and practice guides) to support the key processes of assessment, analysis, decision-making, intervention, review and evaluation is an important feature of the HfCF approach.

# 2.0 Adverse Childhood Experiences -an introduction

The purpose of this introductory guide is to demonstrate how a 'Modular, Trauma – Informed 'approach to intervention can be utilised to develop a treatment plan to reduce the harmful impact of Adverse Childhood Experiences (ACEs) Since the introduction of ACEs by Felliti and his colleagues there has been a growing awareness of the long-term impact of ACEs on physical and mental health, and the potential to prevent those impacts by identification and providing treatment for ACEs. The challenge is to both identify the relevant ACEs to work with, and to provide treatment for the common multiple forms of ACEs Practitioners encounter in social care, health, education and youth justice. We will argue that the solution is the utilisation of a modular, trauma informed approach which can fit with the profile of needs of the child, young person, parents and families.

# 3.0 Adverse Childhood Experiences – Literature Review

## 3.1. The first major ACE study

Felliti et al (1998) examined relations between the number of ACEs reported by more than 17000 individuals in the USA and their subsequent health as adults. The research found that the more ACE types that individuals reported in their childhood - *Emotional Abuse, Physical Abuse, Sexual Abuse, Physical Neglect, Emotional Neglect, Mother treated Violently, Household substance abuse, Household Mental illness, Incarcerated household member, and Parental separation or Divorce* the greater their risks of health-harming behaviours (eg, smoking or sexual risk taking) and both infectious and non-communicable diseases (NCDs). Supported by international work to standardise measurement of ACEs and their effects on health, these findings have since been replicated in studies from low-income and middle-income and high-income countries.

Hughes *et al*. (2017) published a recent systemic review and meta-analysis of the effect of multiple Adverse Childhood Experiences on health involving 37 studies describing 253,719 Individuals. Those with at least four recorded ACEs were at increased risk for poor health outcomes compared with individuals with no ACEs. Associations were *strongest* for sexual risk taking, mental ill health, and problematic alcohol use and *strongest* for problematic drug use and interpersonal and self-directed violence

## 3.3. Assessments of ACE's in childhood.

Finkelhor (Finkelhor et al 2012) has pointed out that the average age of respondents when they supplied information about their childhood experiences was 55 to 57 years. Using an adapted form of their *Juvenile Victimisation Questionnaire*, Finkelhor *et al*. added *Peer Victimisation – excluding siblings, property victimisation – excluding siblings - exposure to community violence, someone close having had a bad accident, death or illness, low socio-economic status, parents always arguing, below average grades* and *no good friends* to the original ACEs' form.. The newly added ACEs were strongly

associated with longer term impacts– *peer victimisation, property victimisation, parents always arguing, having no friends, someone close having a bad illness or accident and community violence*.

### 3.4. Multiple ACE's and Polyvictimisation.

In parallel with Felitti's work on ACE's and the harmful impact of multiple ACE's, increasingly complex forms of maltreatment are being identified. Finkelhor and colleagues (2007) introduced the notion of Poly-Victimisation or Multi-Type Maltreatment (i.e. experiencing a number of types of maltreatment). These young people were more likely to suffer sexual abuse, to have witnessed the abuse of a sibling, to have been abused themselves. Their responses – anger and aggression put them at risk of further victimisation. This group had higher levels of clinical symptoms, depression and anxiety, they lived in families characterised by interpersonal violence, disruption, and adversity. The cumulative impact of Polyvictimisation, and resulting Interpersonal Violence and Bullying triggered around the age of 14 years of

### 3.5 Research on ACE's in specific childhood contexts.

#### 3.5.1 Children suffering abuse and neglect

A population of children who were identified as having suffered abuse and neglect, and who presented to child protection agencies had high rates of ACEs (Garcia *et al*. 2017). Half (50%) of the children identified had experienced *significant traumatic loss/separation* and *exposure to domestic violence*. Under half (40%) of the children had experienced parenting by individuals who were anxious, depressed or were abusing substances or alcohol. Higher number of ACEs were associated with chronic disruption of foster care placements in general, and higher levels of depression, withdrawal and rule-breaking behaviour. (Villodos *et al*. 2016).

#### 3.5.2 Children who self- harm

Longitudinal studies – e.g. the LONGSCAN Thompson et al 2012) demonstrated that Cumulative lifetime adversities predict teen suicidal ideation—the number of lifetime adversities –maltreatment, witnessing violence, and residential instability - significantly predicted teen suicidal ideation The effects of adolescent adversities are strongest at low levels of childhood adversities; and this effect is reversed at high levels of childhood adversities. This is consistent with a vulnerability- stress model with low and moderate levels of adolescent adversities, but with a suppression/stress inoculation effect at high (i.e., 5 or more) adolescent adversities. Although usually ignored by child protective services, there is growing evidence of the noxious effects of maltreatment occurring in adolescence, including psychological abuse

#### 3.5.3 ACEs and Children's Health

The LONGSCAN prospective study of children at risk examined the relationship between previous adverse childhood experiences and somatic complaints and health problems in early adolescence, and examined the role of the timing of adverse exposures. (Flaherty et al 2013 ) Eight categories of adversity (psychological maltreatment, physical abuse, sexual abuse, neglect, caregiver's substance use/alcohol abuse, caregiver's depressive symptoms, caregiver treated violently, and criminal behavior by household member) experienced during the first 6 years of life, the second six years of life, the most recent 2 years, and overall adversity More than 90% of the youth had experienced an adverse childhood event by age 14. There was a graded relationship between adverse childhood exposures and any health problem, while 2 and ≥3 adverse exposures were associated with somatic

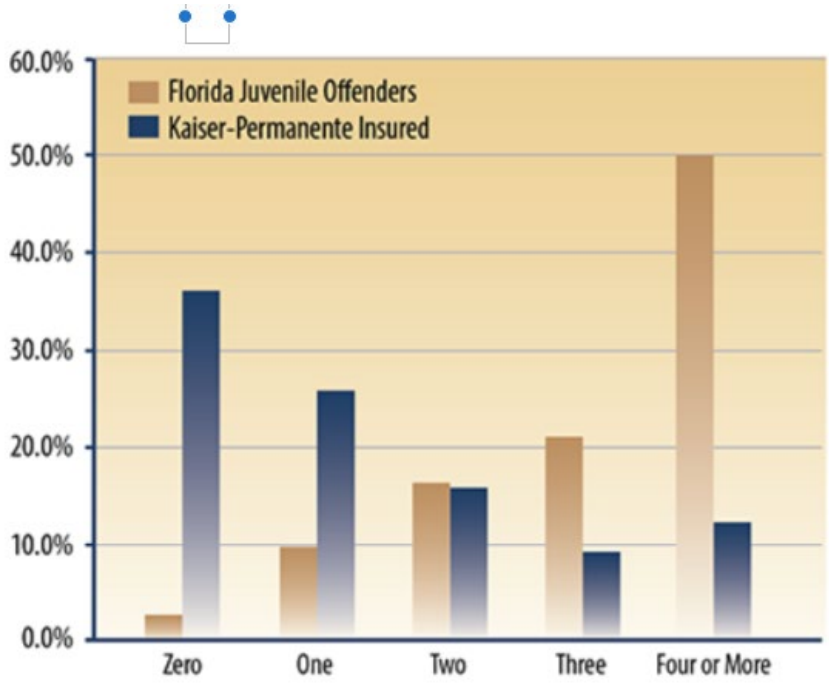
complaints. Recent adversity uniquely predicted poor health, somatic complaints and any health problem. Childhood adversities, particularly recent adversities, already impair the health of young adolescents.

### 3.5.4 The harmful effects of ACEs associated with children and young people in conflict with the law.

Research on adverse and traumatic experiences, as well as mental health problems of children in conflict with the law referred to offending services has revealed higher prevalence rates of adversity and trauma compared to young people in the general population

They are more likely to have experienced multiple forms of trauma (Abram et al., 2004).

A key study on ACEs in the 'lives of juvenile offenders' - children and young people in conflict with the law (Baglivio and Epps et al 2014) examined the prevalence of ACEs in a population of 64,329 juvenile offenders in Florida. The Florida study showed that young people who had been referred to the juvenile justice system had markedly higher prevalence rates than those individuals in the original (ACE) Study.




There were higher rates of all 10 basic ACEs in girls than in boys, with an average composite score of 4.29 ACEs for females and 3.48 for males. Nearly half (45.1 percent) of girls reported five or more ACEs compared with 27.4 percent of boys. Among the 10 ACEs studied, family violence (84 percent for females, 81 percent for males), parental separation or divorce (84 percent, 78 percent) and household member incarceration (68 percent, 65 percent) were most common. The least common were household mental illness (12 percent among females, 8 percent among males) and physical neglect (18 percent, 12 percent). The biggest contrast between the genders was sexual abuse, at 31 percent for girls and 7 percent for boys. There was also a higher rate of re-offending when there were higher rates of ACEs.

The research on offending has been extended to gang-membership and substance misuse, Wolff et al 2019 looked at their data to evaluate whether ACE exposure at early stages of development predicts gang involvement by age 18. There was a relationship but that much of the effect of ACEs on later gang involvement can be explained by their impact on current substance abuse and difficult temperament.

Specific links with sexually harmful responses have been demonstrated, eg the follow up of sexually abused boys at Gt Ormond Street which showed that exposure to violence against maternal figures, neglect and emotional abuse were the factors which were associated with the development of sexually harmful behaviour. ( Skuse et al.2000 )

## 4.0 A review of the evidence of effectiveness and limitations of Interventions for ACE's

Hughes et al state *(2017) that' multiple ACEs 'add to harmful impact on life prospects, including education, employment, and poverty. There needs to be a focus on early intervention. Treatment and prevention of many health conditions requiring multiple underlying ACEs to be addressed" They argue that ACE-informed practice can (should ) be developed across multiple settings, including schools, criminal justice agencies, and social care assessment of children and their families in contexts of concern when children are showing evidence of being subject to maltreatment, with associated parental mental health, substance abuse, or conflict*.

Bellis et al (Bellis et al 2018) have demonstrated that Childhood community resilience assets - being treated fairly, supportive childhood friends, being given opportunities to use your abilities, access to a trusted adult and having someone to look up to - were independently linked to better outcomes which suggests that appropriate intervention could be effective in promoting resilience.

Pachter et al (2017) in describing the development of community ACEs services identified foci of local activity in the areas of professional training and workforce development, community education, and local practical interventions around adversity, trauma and resiliency

What is the evidence of the effectiveness of these approaches to reduce the harmful impacts of ACEs? A systematic review of trials to improve child outcomes associated with ACEs (Marie-Mitchell and Kostolansky, 2019) was able to identify 20 Random Control Trials. The studies all focused on children under five years of age. The commonest ACE was parental mental health: There were fewer parent alcohol, substance abuse or domestic violence associated ACEs studied. Multicomponent medium- to high-intensity interventions improved parent-child relationships. However, there was no research which included children older than 6 years of age, or on improving child outcomes for other ACEs.

Reviewing interventions for ACEs Finkelhor (2017, p. 175) comments that '*it is not at all clear that we have evidence-based interventions for high ACE scores, and certainly the protocols for packaging such information into a rigorous intervention are still in the early stages of development'.*

There is a more extensive research on interventions for maltreatment across the age-range (Macdonald *et al*. 2016) identified 198 studies including 62 trials, the majority for single forms of maltreatment. Trauma Focused CBT showed the strongest evidence of effectiveness for PTSD, which included reduction of traumatic symptomology, and co-morbid anxiety and depression. Macdonald states that '*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'* (pp. vii and 38).

Marchette and Weisz (2017) draw attention to the paradox that there are many focal treatment manuals in the child mental health field, and specific forms of maltreatment and adversity, that are not used widely in everyday practice. This deficit raises the risk of confusion and muddle if practitioners attempt to apply a focal treatment for one type of maltreatment to another type of maltreatment that requires a different treatment approach (Bentovim, Vizard & Gray, 2018)

## 5.0 The development of the modular, trauma -informed *Hope for Children and Families Intervention Resources* (HfCF)

**5.1. ACEs** have a significant impact on the mental health of the developing child, and into adult life and have a cumulative harmful impact. There are effective interventions, but not for the heterogeneity of responses associated multi-type maltreatment and multiple adversity. A modular approach may be more effective in meeting these complex situations.

**5.2. *Modular Common Element Treatments*** *Modular common practice elements* are therapeutic procedures derived from single -focal treatment manuals including approaches which may be theoretically very different (Chorpita and Daleiden 2009). Practice elements embedded in evidence-based treatments were identified in more than 500 random control trials and catalogued into an online searchable database classifying the common functions, processes, and elements across evidence -based programs – the Managing and Adapting Practice (MAP system).".

Common practice elements can be developed into modules which target disorders and problems, organised into menus of treatment procedures, to fit the needs of the individual and their family and modified to meet their changing needs during the therapeutic process. There is evidence of the benefits of this approach. Chorpita and Weisz (2009) designed the MATCH-ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and Conduct), a multi-disorder intervention system that incorporates treatment procedures (elements) and treatment logic (coordination) corresponding to four successful evidence-based interventions for childhood anxiety, depression, trauma, and conduct problems, with modifications to allow the system to operate as a single protocol.

## 6.3 Development of the Hope for children and families Resources

Given the frequent occurrence of anxiety, depression, trauma and conduct problems associated with ACEs and maltreatment, and the effectiveness of the treatment approach, the MATCH-ADTC paradigm was adopted to develop an approach to train professionals to prevent abusive and neglectful parenting and the associated impairments of children and young people's health and development – key factors associated with ACEs.- *the Hope for Children and Families Intervention Resources.*

Common practice elements were derived from 22 Randomised Controlled Trials (RCTs) identified for the treatment of the different forms of maltreatment (Bentovim & Elliott 2014). The 47 common practice elements that emerged utilizing the MAP system, were categorised as focusing on the child, parents and the family as a whole.

These elements were integrated into modules, with consistent information, on theory and research provide a step-wise approach to intervention with scripts, guidance notes, hand-outs, and activities that can be used by a wide range of practitioners working in different settings and stages to deliver

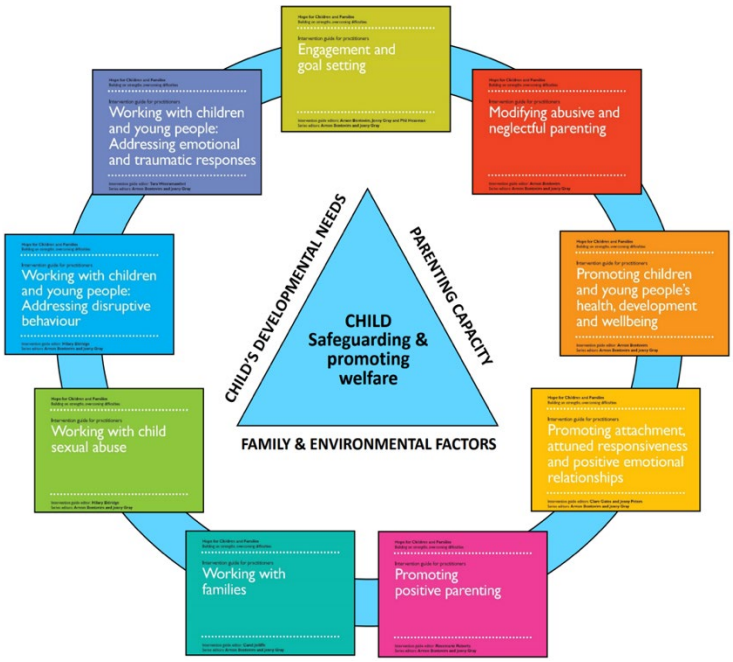
the evidence-based services. *The Framework for the Assessment of Children in Need and their Families* (Department of Health *et al*., 2000) provided the basis for organising the information in the various modules into a set of intervention guides (Bentovim & Gray, 2016, 2017) relevant to everyday practice with children and families.

## 6.0 Introduction to the Intervention Guides

Nine intervention guides for practitioners have been designed to meet the common patterns of children and young people's responses to ***Adverse Childhood Experiences (ACEs)***, through specific modules to address traumatic responses as well as the co-morbid responses associated with multiple ACEs. They also include modules that are aimed at identifying and modifying sources of re-traumatisation within the family and community, improving and strengthening the quality of family life, promoting positive parenting, warmth, secure attachments and positive development. These reinforce family strengths and promote recovery and resilience in children.

When working with a child and family**,** a thorough assessment is essential to assist the practitioner to establish the profile of strengths and difficulties in the child/young persons' health and development, parenting capacity and individual, family and environmental**.** This guide sets the scene through modules that help the practitioner engage with children, young people and their family, promote a sense of hopefulness about what can be achieved through working with the practitioners, and setting collaborative goals (Bentovim & Gray (Eds.), 2016; 2017; Bentovim et al., 2017).

**A seven-stage model** of assessment, analysis, planning and reviewing interventions in child wellbeing and safeguarding contexts forms the basis of the process




**: Stages of assessment, analysis, planning and interventions**

| | |
|---|---|
| **Stage 1** | Considers the nature of the child's ACEs identified from the check list, and the aims of the intervention having ensured immediate health needs have been met, and basic care and safety have been established. |
| **Stage 2** | Gather assessment information on the child's developmental needs, parenting capacity, and family and environmental factors. This will include measures of the presecense and impact of ACEs, e.g. the Trauma Check List (Briere, 2001; 2005), the Strengths and Difficulties Questionnaires (Cox & Bentovim, 2000; Goodman, 1998), Assessments of Parenting and the environment of care – The HOME assessment (Cox et al., 2009) and the Family Assessment (Bentovim & Bingley Miller, 2001). |
| **Stage 3:** | Organise the information using the Assessment Framework and establish a chronology of significant events in the child's life – including earlier ACEs. |
| **Stage 4:** | Analyse the patterns of strengths and difficulties including risks and protective factors within the family context and community, understanding the origins of ACEs within the family or community. |
| **Stage 5:** | Make judgements based on a systemic analysis about the therapeutic needs of the child, and the capacity of the family to meet them within the context of their wider family and environment. |
| **Stage 6** | Make decisions and develop a plan of intervention. |
| **Stage 7** | Implement the plan of intervention, monitor and review progress. |

## 6.2 Direct Work with Children and Young people

Direct work with children and young people exposed to various ACEs in the home or community can be undertaken drawing on the following three guides: *Working with children and young people: Addressing emotional and traumatic responses (*Weeramanthri, 2017), *Working with children and young people: Addressing disruptive behaviour* (Eldridge, 2017), and *Working with Child Sexual Abuse* (Eldridge, 2017). The chosen modules, that are relevant to the needs of the child or young person, are delivered by a practitioner working in partnership with a supportive parental figure/caregiver who can continue to work on the therapeutic procedures – e.g. to encourage the completion of a trauma

narrative. The focus is on working collaboratively with the child after an assessment process has been completed, and the profile of the child's needs established.

The earlier modules in the guide, *Working with children and young people: Addressing emotional and traumatic responses,* are generic and useful for all children subject to ACEs, and have a significant role in promoting resilience and wellbeing. These generic modules aim to provide the child with a toolkit of skills to help them manage their feelings, thoughts and behaviours. They are also useful to the practitioner in building relationships with children and helping engage them. They provide the basis of specific therapeutic work with specific responses to ACEs. There are three specific modules on anxiety, mood and trauma problems, including developing an account of the specific ACEs suffered. These should be selected on the basis of the problem the child is experiencing.

Disruptive responses are some of commonest responses to ACEs and the guide*, Working with children and young people: Addressing Disruptive Behaviour,* includes modules on developing an alternative 'Good Life', managing disruptive behaviour, and developing a capacity for assertive rather aggressive behaviour, and developing positive relationships with family and friends.

Two linked themes are included in the guide *Working with Child Sexual Abuse.* The first focuses on working to enhance the resilience of children and young people who have been sexually abused by a family member or by a trusted member of the community or has been exploited within the community; and the second, working with children and young people who have displayed harmful sexual behaviours (a frequent response to earlier extensive ACEs).

## 6.3 Working with Parents

Four intervention guides are focused on Parenting. These are: *Promoting positive parenting* (Roberts, 2017); *Promoting attachment, attuned responsiveness, and positive emotional relationships* (Gates & Peters, 2017); *Promoting children and young people's health, development and wellbeing (*Bentovim, 2017); and, *Modifying Abusive and Neglectful Parenting* (Bentovim, 2017). They provide a broad range of modules to help promote positive parenting, health and development when children and young people have experienced multiple ACEs within the family and social community environment. Modules focus on improving the quality of care and addressing neglect as a factor contributing to the vulnerability of a child to ACEs in the past and future. Although the focus is on parenting, the modules often include direct work with parents and children together, to directly manage or promote positive and responsive behaviours.

## Specific Modules Working with Parents

### 6.4 Promoting Positive Parenting

The aim of promoting positive parenting is to understand factors associated with the development and maintenance of negative behaviour, and to introduce a number of different approaches to improve the behaviour through positive approaches. Table 5 sets out the modules that can be used to improve children's behaviour through positive parenting.

## 6.5 Promoting Attachment, Attuned Responsiveness and Positive Emotional Relationships

This guide stresses the importance of the secure attachment; explains the nature of secure and insecure attachments; and, helps practitioners to identify the nature of the attachment between the parents and their infant, growing child and adolescent. Table 6 sets out the modules to promote attachment, attuned responsiveness and positive emotional relationships between children and young people and their parents/caregivers.

## 6.6 Promoting children and young people's health and development

The guide presents parents with information about children and young people's development, including how the brain develops. It is intended to help parents understand how children develop at different stages throughout their childhood, as well as help them to understand their parenting role. Table 7 sets out modules to be used to help parents promote their children and young people's health and development.

## 6.7 Modifying abusive and neglectful parenting

The modules set out in Table 7 set out how practitioners address the needs of parents who have caused ACEs, having been responsible for physically, sexually or emotionally abusive actions towards their children, have seriously neglected their care, or have exposed their children to domestic violence.

## 6.8 Working with Families

This guide, *Working with Families* (Jolliffe, 2017), helps the practitioner work with parents/caregivers and children together to promote communication and manage the conflict and difficulties which are part of the process of achieving stability and resilience, whether the child's adversity originates in the family context or community. Table 9 sets out how the modules can be used when working with families.

# 7.0 Implementing the HfCF Intervention Resources

The implementation approach was piloted with a variety of practitioners working in different settings, including in social care/child protection, health, education and young offender services (Gray, 2015). The pilots consisted of a programme of training workshops and coaching sessions attuned to the practitioner's role and context. These helped each practitioner construct and undertake assessments, analysis, plans and then interventions (Pizzey et al., 2016) that responded to the specific needs of the children and families with whom they were working. These included those who have suffered ACEs and complex, multi-type maltreatment.

## References and relevant reading


Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. Archives of General Psychiatry, 61, 403–410.

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

Bentovim, A. and Bingley Miller, L. 2001. *The Family Assessment: Assessment of Family Competence, Strengths and Difficulties.* York: Child and Family Training.

Bentovim, A., Cox, A., Bingley Miller, L. and Pizzey, S. 2009. *Safeguarding Children Living with Trauma and Family Violence: A Guide to Evidence-Based Assessment, Analysis and Planning Interventions.* London: Jessica Kingsley.

Bentovim, A. 2015. Burdens and consequences of child maltreatment. In Bentovim, A. and Gray, J. (eds). *Eradicating Child Maltreatment*. London: Jessica Kingsley Publishers; pp. 17-50.

Bentovim, A. and Elliott, I. 2014. Targeting Abusive Parenting and the Associated Impairment of Children. *Journal of Clinical Child & Adolescent Psychology*. Available http://www.tandfonline.com/loi/hcap20 http://www.tandfonline.com/loi/hcap20http://www.tandfonline.com/loi/hc.

Bentovim, A, and Gray, J. (eds). 2016; 2017. *Hope for Children and Families: Building on Strengths, Overcoming Difficulties.* York: Child and Family Training.

Bentovim, A., Gray, J., Heasman, P. and Pizzey, S. 2017. *Engagement and goal setting.* In A. Bentovim and J. Gray (eds) *Hope for Children and Families: Building on Strengths, Overcoming Difficulties*. York: Child and Family Training.

Bentovim, A. 2017. *Modifying abusive and neglectful parenting.* In A. Bentovim and J. Gray (eds) *Hope for Children and Families: Building on Strengths, Overcoming Difficulties*. York: Child and Family Training.

Bentovim, A. 2017. *Promoting children and young people's health, development and wellbeing.* In A. Bentovim and J. Gray (eds) *Hope for Children and Families: Building on Strengths, Overcoming Difficulties*. York: Child and Family Training

Bentovim A , Vizard E. and Gray J 2018 Editorial Perspective: Treatment of complex maltreatment – beyond the NICE guideline? Manuals, muddles or modules *Child and Adolescent Mental Health* 23, No. 3, 2018, pp. 297–300 doi:10.1111/camh.12280

Calam, R.M., Cox, A.D., Glasgow, D.V., Jimmieson, P. and Groth Larsen, S. (2000) 'Assessment and therapy with children: can computers help?' *Child Clinical Psychology and Psychiatry* 5, 3, 329–343.

Cecil, CAM., Viding, E., Fearon, P., Glaser D, and McCrory, EJ. 2017. Disentangling the mental health of childhood abuse and neglect. *Child Abuse and Neglect* **63**: 106-119.

Chorpita, BF. and Weisz, JR. 2009. *Modular Approach to Children with Anxiety, Depression, Trauma and Conduct Match-ADTC.* Satellite Beach FL: PracticewiseLCC.

Chorpita BF, Daleiden EL. (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 BFL, Daleiden EL, Park AL, Ward AM, Levy MC, Cromley T, Chiu AW, Letamendi AM, Tsai KH, Krull JL. (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. DOI: 10.1037/ccp0000133.

Cicchetti D. and Lynch M 1993 *Toward an ecological/transactional model of community violence and child maltreatment: consequences for children's development* Psychiatry ;56(1):96-118.

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

Cox, A., Pizzey, S. and Walker, S. 2009. *The HOME Inventory: A Guide for Practitioners – The UK Approach.* York: Child and Family Training.

Department of Health, Department for Education and Employment, Home Office. 2000. *The Framework for the Assessment of Children in Need and their Families*. London: The Stationery Office.

Eldridge, H. 2017. *Working with children and young people: Addressing disruptive behaviour.* In A. Bentovim and J. Gray (eds) *Hope for Children and Families: Building on Strengths, Overcoming Difficulties*. York: Child and Family Training.

Eldridge, H. 2016. *Working with child sexual abuse.* In A. Bentovim and J. Gray (eds) *Hope for Children and Families: Building on Strengths, Overcoming Difficulties*. York: Child and Family Training

Felitti V.J., Anda RF, Nordenberg D *et* al. (1998) Relationship of Childhood Abuse and Household Dysfunction to many of the leading causes of Death in Adults: The Adverse Experience (ACE) study. *Am Journal of preventative medicine* **14** 245- 258.

Finkelhor, D. 2018. Screening for Adverse Childhood Experiences (ACEs) Cautions and Suggestions. *Child Abuse and Neglect* **85**: 174 -179

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.

Finkelhor D, Omrod RK, Turner HA. 2007. Poly-victimisation: A neglected component in child victimization. *Child Abuse and Neglect* **31**: 7-26.

Finkelhor D, Turner H.A. Shattuck A Hamby S.L. 2015 *Prevalence of Childhood Exposure to Violence, Crime, and Abuse: Results From the National Survey of Children's Exposure to Violence.*JAMA Pediatrics 168 746-54

Garcia, AR., Greeson, JKP., Thompson, A., DeNard, C. and Gupta, M. 2017. Adverse childhood experiences among youth reported to child welfare: results from the national survey of child & adolescent wellbeing. *Child Abuse and Neglect* **70**: 292-302.

Gates, C. and Peters, J. 2017. *Promoting attachment, attuned responsiveness and positive emotional relationships.* In A. Bentovim and J. Gray (eds) *Hope for Children and Families: Building on Strengths, Overcoming Difficulties*. York: Child and Family Training.

Gray, J. (2015) *Hope for Children and Families Intervention Resources Pilot Project*. *Reports submitted to the Department for Education*. York: C&FT.

Hughes, K. Bellis, M.A. Hardcastle, K.A. et al (2017) The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis *Lancet Public Health* 2017; 2: e356–66

Jolliffe, C. 2016. *Working with families.* In A. Bentovim and J. Gray (eds) *Hope for Children and Families: Building on Strengths, Overcoming Difficulties*. York: Child and Family Training.

Koss, K.K., Gunnar, M.R. (2018) Annual Research Review; Early adversity - the hypothalamic - pituitary - adrenocortical axis, and child psychopathology. *Journal of Child Psychology and Psychiatry* **59**: 327 b-346

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., and Taussig, H. (2009) Intervention to prevent child maltreatment and associated impairment. *Lancet*, *373*, 250–266.

Marchette LK, Weisz JR. 2017. Practitioner Review: Empirical evolution of youth psychotherapy toward transdiagnostic approaches. *Journal of Child Psychology and Psychiatry* **58** (9): 970-984.

McGee, C., Hughes, K., Quigg, Z., Bellis, M., Larkin, W. & Lowey, H. A (2015) Scoping Study of the Implementation of Routine Enquiry about Childhood Adversity (REACh): **http://www.cph.org.uk/wp-content/ uploads/2015/07/REACh-Scoping-Study-BwD. pdf**

McCrory E, Gerin MI, 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.

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

National Institute for Health and Care Excellence. 2005 and 2018 *NICE Guideline. Post-traumatic Disorder* London

Pinheiro, P.S. (2006) *World Report on Violence against Children*. Geneva: United Nations.

Pizzey, S., Bentovim, A., Cox, A., Bingley Miller, L. and Tapp, S. 2016. *The Safeguarding Children Assessment and Analysis Framework.* York: Child and Family Training.

Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett C., Horwat N., and Collishaw S. (2011) *Child abuse and neglect in the UK Today*. London: NSPCC.

Roberts, R. 2016. *Promoting positive parenting.* In A. Bentovim and J. Gray (eds) *Hope for Children and Families: Building on Strengths, Overcoming Difficulties*. York: Child and Family Training.

Villodas, M.T., Cromer K.D. et al (2016) Unstable child welfare placements, early physical and mental health, role of adverse childhood experiences and PTSD *Child Abuse and Neglect* 62, 76 -88

Weeramanthri, T. 2016. *Working with children and young people: Addressing emotional and traumatic responses.* In A. Bentovim and J. Gray (eds) *Hope for Children and Families: Building on Strengths, Overcoming Difficulties*. York: Child and Family Training.

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