LETTING THE FUTURE IN

A THERAPEUTIC INTERVENTION FOR CHILDREN AFFECTED BY SEXUAL ABUSE AND THEIR CARERS

An evaluation of impact and implementation

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EVERY CHILDHOOD IS WORTH FIGHTING FOR

Impact and Evidence series

This report is part of the NSPCC's Impact and Evidence series, which presents the findings of the society's research into its services and interventions. Many of the reports are produced by the NSPCC's Evaluation department, but some are written by other organisations commissioned by the society to carry out research on its behalf. The aim of the series is to contribute to the evidence base of what works in preventing cruelty to children and in reducing the harm it causes when abuse does happen.

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ACKNOWLEDGEMENTS

KEY FINDINGS

Letting the Future In is a structured guide to therapeutic intervention with children affected by sexual abuse. It is grounded in an understanding of trauma, attachment and resilience. Largely psychodynamic in nature, it sees the therapeutic relationship between child and practitioner as central. It was developed by the NSPCC and has been implemented by 20 teams since 2011. The intervention is available to children aged between four and 17 who have made a disclosure and who live with a safe parent/carer. Children receive up to four therapeutic assessment sessions followed by up to 20 intervention sessions. Carers are offered help with the impact of discovering that their child was sexually abused, and to support their child's recovery.

The implementation of *Letting the Future In* and its impact were independently evaluated by the universities of Bristol and Durham. The evaluation included qualitative case studies and the largest randomised controlled trial of a therapeutic intervention for child sexual abuse ever undertaken.

- 242 children aged 6–16 years took part in the randomised trial. Three quarters were girls and one in six was disabled. Most had experienced contact sexual abuse – inappropriate touching or penetration. They were almost twice as likely to have been abused by someone in their family as by someone outside it. Four in ten known perpetrators were under 18 years of age, and almost all were male.

- On initial assessment, over half of young people and children over eight reported 'clinical' level scores on a standardized measure of psychological and behavioural symptoms, rising to 70% when one or more 'significant difficulties' were included. Parents/ carers reported 'clinical' or 'significant difficulty' level scores for 92% of younger children under eight. Over half of older children and young people, and around one third of younger children had experienced three or more types of victimization, such as physical and verbal abuse at home and bullying by other children, in addition to sexual abuse.

- After assessment, children were randomised to immediate intervention or a six-month waiting list control group before receiving the intervention. All children were reassessed after six months and followed up at twelve months.

- At six months, the proportion of older children and young people in the intervention group with clinical plus significant difficulty scores remaining in the study had reduced from 73% to 46%. Taking into account children who had failed to engage or who had dropped out early, the reduction was from 68% to 51%. There was no statistically significant change in scores for the waiting list control group, so improvements in the immediate intervention group can be attributed to the intervention.

- For younger children, there was no change in either the intervention or control group over the six months. However, there was some evidence of a reduction in the intervention group at the 12 month follow-up. This suggests that improvements may take longer to achieve or to be recognised by the carers who completed the measures.

- Around half the safe carers had clinical levels of parenting stress at initial assessment. Six months later, there was no change in either the intervention or waiting list control group. An unanticipated finding, which may partially explain this result, was that only 40% of carers actually received the carer's intervention in the first six months.

- The majority (86%) of practitioners delivering *Letting the Future In* were social workers, many with additional training in therapeutic work. Most also had at least six years' experience of direct work with children affected by sexual abuse and were skilled in developing strong therapeutic relationships with children and young people.

- The intervention was, in the main, delivered consistently across teams. Interventions used with younger children included symbolic play, creative therapies and awareness and management of feelings. Older children and young people received more interventions concerned with the awareness and management of feelings and identity and self-esteem, in addition to creative therapies.

- *Letting the Future In* was highly valued by the children and their carers who were interviewed. They were unanimous in thinking that the intervention had resulted in positive changes. They identified improved mood, confidence, and being less withdrawn, a reduction in guilt and self-blame, reduced depression, anxiety and anger, improved sleep patterns and better understanding of appropriate sexual behaviour.

- Individual carer sessions featured counselling, awareness and management of feelings, and socio-educative work, more commonly for carers of younger children. Those carers who used these sessions found their own practitioner extremely helpful in dealing with feelings of guilt, and learning how to understand their child's response to the abuse and to support their recovery.

- On average, children received 16 individual sessions, with a further four sessions involving carers. The mean cost of providing *Letting the Future In*, including meetings with external professionals, management costs, staff training and supervision was estimated as £2,300 per case. This compares to an average cost of cases with a range of mental health problems seen by a multidisciplinary Child and Adolescent Mental Health Service of almost £5,000 (PSSRU, University of Kent 2012).

EXECUTIVE SUMMARY

Letting the Future In is a structured guide to therapeutic intervention with children affected by sexual abuse. The guide was developed by the NSPCC and has been implemented by 20 NSPCC teams across England, Wales and Northern Ireland since 2011. It is available to children aged between four and 17 who have made a disclosure and experienced sexual abuse, live with a safe carer with no planned moves and have no diagnosed learning disability.

Letting the Future In is grounded in an understanding of trauma, attachment and resilience. It is largely psychodynamic in nature and emphasises the therapeutic attunement of the practitioner to the child's emotional responses to abuse, which typically include betrayal, powerlessness, shame and traumatic sexualisation. It sees the therapeutic relationship between child and practitioner as 'core' and employs creative therapies with work on the awareness and management of feelings. It also draws on other methods including counselling and socio-educative approaches. Children receive up to four therapeutic assessment sessions followed by up to 20 intervention sessions, extended up to 30 if necessary. At the same time, their safe carer is offered up to eight sessions to help them process the impact of discovering that their child was sexually abused, and to support the child in their recovery.

There are few rigorous evaluations of therapeutic interventions for these children. Recognising that *Letting the Future In* is new and untested, the NSPCC commissioned a process and impact evaluation from the universities of Bristol and Durham.

Methodology

The research questions for the **impact evaluation** were:

1. What are the outcomes for children and young people affected by sexual abuse of providing *Letting the Future In* in NSPCC service centres?

2. What is the cost-effectiveness of this service[1]?

3. What is the effectiveness of the support intervention received by the 'safe carers'?

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1   The cost effectiveness study is still proceeding and will be reported in a subsequent publication.

These were addressed using a pragmatic ('real world') randomised control trial (RCT) with a waiting list control group. Children referred and accepted for the intervention were randomised to either an immediate intervention group or a waiting list group (for six months, after which they were offered the intervention). The primary outcome was the change in the proportion of children with clinical levels of symptoms or significant difficulties between assessment on referral, and six-month research follow-up. These were measured using standardised instruments, the Trauma Symptoms Checklist or Trauma Symptoms Checklist for Young Children (TSCC/TSCYC) (Briere, 1996; 2001). Secondary outcomes included the change in the proportions of parents with clinical levels of parent/carer stress for safe carers (Parenting Stress Index) (Abidin, 1995).

The **process evaluation** asked:

1. How is *Letting the Future In* delivered?

2. What are children's, safe carers' and practitioners' experiences and perceptions of the intervention?

The delivery of *Letting the Future In* was investigated through case studies of eight NSPCC teams comprising interviews with six managers, 12 practitioners and four external professional referrers. Interviews explored referral, delivery and perceived outcomes of the intervention. Family case studies were undertaken with 12 children and young people and 17 carers to understand the acceptability of the service, perceptions of its delivery, and impact. The evaluation also included a specific qualitative study to explore the nature and quality of the therapeutic relationship developed during *Letting the Future In* in which 24 children, carers and practitioners took part.

Key Findings

Impact evaluation

Children and young people

In total 242 families agreed to participate in the evaluation. Three quarters of abused children were girls, 9% were of Black and Minority ethnic background, 17% had one or more disabilities and 12% were 'looked after'. Children were aged between 6–16 years, with a mean age of 10.7 years. Most children had experienced contact sexual abuse comprising inappropriate touching or penetration. Children were almost twice as likely to have been abused by someone in their family as by someone outside it, although abusers may still have been known to the children. Four in ten known perpetrators were young people aged under 18 years, and 93% of known perpetrators were male.

The findings for children and young people are reported according to the outcome measures used. The self-report measures, including the TSCC, are designed and standardised for 'older children' and young people i.e. over eight but, in a few cases they did not appear to understand the questions and a proxy measure was completed by the parent or carer. Proxy measures, including the TSCYC, were completed for all children under eight.

Over half (57%) of older children and young people in the evaluation had a 'clinical' level score on at least one TSCC subscale at baseline, rising to 70% when children with one or more 'significant difficulties' were included. In the younger age group, parents/carers reported that 86% had clinical scores on at least one TSCYC subscale, which rose to 92% when 'significant difficulties' were included.

Over half of older children and young people, and around one third of young children (under 8 years), had experienced three or more types of abuse in addition to sexual abuse.

Outcomes for older children and young people

Results are reported in two ways: for 'Analysis Completers', children for whom data was collected at baseline (T1) and six-month follow-up (T2), and an intention to treat (ITT) analysis, using multiple imputation techniques, which takes account of all referred children, not just those who received the intervention. Results were consistent between analyses, although the ITT analysis was always a little more conservative because it included children who failed to engage and those who dropped out early without completing the intervention or the measures; these children may have had more difficult family and personal circumstances.

In the 'Analysis Completers' group, nearly three-quarters (73%) of older children and young people scored above the clinical/significant difficulty level at baseline, reducing to 46% at the six month follow-up. This difference was statistically significant. There was a much smaller and statistically non-significant reduction in the proportion with clinical and difficulty scores in the waiting list control group (from 67% to 61%). These findings were reflected in the ITT analysis which showed a statistically significant reduction from 68% to 51% for the intervention group but not the waiting list group. Because there were no baseline differences between the groups, the improvements in the intervention group are attributable to the intervention.

Outcomes for younger children

For younger children, the TSCYC scores showed no change in either the intervention or control group between baseline and six month follow-up. The proportions of younger children with at least one clinical/significant difficulty level scores on the TSCYC remained very similar. However, there was some evidence of a reduction in the intervention group at the 12 month follow-up. This suggests that effects of the intervention may take longer to achieve. It may also take longer for their carer to recognise improvement because they are dealing with their own responses to their child's abuse.

Outcomes for Safe Carers

Around half the safe carers had clinical levels of parenting stress at initial assessment. Six months later, there was no change in either the intervention or waiting list control group. An unanticipated finding was that only 40% of carers actually received the carer's intervention. In most cases this was provided towards the end of the work with the child. It is perhaps not surprising that there was no evidence of change in the first six months. A further six months on there was a statistically significant reduction in the proportion of carers with clinical levels of 'total stress' for Analysis Completers in the intervention group which was down from 54% to 27%, but we cannot necessarily assume that this was a result of the intervention rather than the passage of time.

Process evaluation

Implementing Letting the Future In

The majority (86%) of practitioners delivering LTFI were social workers, many with additional training in therapeutic work. Most also had at least six years' experience of direct work with children affected by sexual abuse. Qualitative interviews found that they understood their role, were confident in their capacity to deliver LTFI and were skilled in developing strong therapeutic relationships with children and young people.

Practitioners were broadly positive about the structure of the LTFI guide. Experienced practitioners reported that it had added value to their work with children, particularly through its emphasis on child-focused and creative methods. The intervention was, in the main, delivered consistently across teams. Interventions used with younger children included symbolic play, creative therapies and awareness and management of feelings. Older children and young people received more interventions concerned with the awareness and management of feelings and identity and self-esteem, in addition to creative therapies.

Less consistent with the guide is the finding that only 40% of cases within the RCT for which we have data had one or more individual sessions with a safe carer. Work with the safe carer also emerged as the most contested area of implementation among the practitioners interviewed. Most would like to see the guidance on aspects of safe carer work revised, including the timing of safe carer sessions, and their core purpose. Safe carer work may be particularly important with younger children who are likely more reliant on their carers.

A peer consultation model of supervision with an experienced practitioner from another team was offered six-weekly. This was generally working well, but most practitioners raised concerns about the lack of clinical supervision which would provide the opportunity to speak about the personal impact of cases outside line management arrangements, where some issues were considered too uncomfortable or inappropriate to raise. There was some evidence that practitioners would benefit from more consistent managerial support and increased access to training and developmental opportunities.

Receiving Letting the Future In

Letting the Future In was highly valued by the children we interviewed. These children had all completed the intervention and we were not able to gauge the experiences of children who had disengaged. Both children and their safe carers were unanimous in thinking that LTFI had resulted in positive changes for children. They identified improved mood, confidence, and being less withdrawn, a reduction in guilt and self-blame, reduced depression, anxiety and anger, improved sleep patterns and better understanding of appropriate sexual behaviour.

Children and their carers highlighted the therapeutic relationship that developed between the child and their practitioner. This is a critical element of LTFI. Practitioners were seen as reassuring, warm, friendly, and honest. Importantly, data from both qualitative interviews and the Therapeutic Alliance Scale indicate that practitioners are skilled at demonstrating these attributes *quickly*.

Carers appreciated the supportive atmosphere fostered within NSPCC service centres by all staff. Not all of those interviewed had engaged with the safe carer intervention. For some, these sessions were offered at a difficult time and they felt unable to take part. This echoes the practitioners' view that the guidance on the timing of carer sessions could be revised.

Individual carer sessions featured counselling, awareness and management of feelings, and socio-educative work, more commonly for carers of younger children. Those carers who did engage found their own practitioner extremely helpful in dealing with feelings of guilt, and learning how to understand their child's response to the abuse and to support their recovery.

Costs

On average, children received 16 individual sessions, with a further four sessions involving carers. The mean cost of providing *Letting the Future In*, including meetings with external professionals, management costs, staff training and supervision was estimated as £2,300 per case. This compares to an average cost of cases with a range of mental health problems seen by a multidisciplinary Child and Adolescent Mental Health Service of almost £5,000 (PSSRU, University of Kent 2012).

Conclusions

Children and young people who have experienced sexual abuse need therapeutic support. At present, the availability of such support is much too little and much too late (NSPCC (2016) *It's Time: campaign report*. London: NSPCC). *Letting the Future In* has been successfully implemented in 20 NSPCC service centres in England, Wales and Northern Ireland. This independent evaluation, which includes the largest randomised controlled trial yet conducted of an intervention for child sexual abuse, provides good evidence of the intervention's effectiveness with children over eight and young people. *Letting the Future In* can and should be further developed, particularly in its use with younger children.

MAIN REPORT

1. Introduction

1.1 Child Sexual Abuse

The World Health Organisation (WHO) (1999) defines child sexual abuse as "the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society." Child sexual abuse is recognised as a major global public health concern (WHO, 1999). Pereda and colleagues (2009) suggest that the sexual abuse of children is a historical constant that occurs across all cultures, societies and social levels. It is seen to result from a complex set of interacting individual, social and cultural factors (Brown et al, 1998).

Awareness of the existence, manifestations and consequences of the sexual abuse and exploitation of children has grown significantly in the UK over the last two decades. While the 1987 Cleveland crisis projected the issue of child sexual abuse firmly into the national spotlight, the 1990s and beyond saw a broadening of concerns beyond the family (Corby, 2000) into awareness of the maltreatment of children in residential care, in situations of organised abuse, in relation to children sexually abused by peers and in gang related contexts (Beckett et al, 2013). This has been accompanied in the UK by a series of high profile scandals of historical child sexual abuse perpetrated by public figures, leading to the establishment of a series of national inquiries into historical abuse throughout the nations of the UK. While media coverage of such scandals has brought the problem of sexual abuse into the public consciousness, there have been concerns that this has led to an unbalanced view of the nature of child sexual abuse as a historical and 'VIP' phenomenon (Wanless, 2015). Recently, there have been attempts to refocus the debate back to the family as the core locus for child sexual abuse. Specifically, the recent Children's Commissioner for England's Inquiry (2015) estimated that child sexual abuse in the family environment comprises about two thirds of all child sexual abuse. The Inquiry offers a broad-based definition of *child sexual abuse in the family environment* as "sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member, or someone otherwise linked to the family context or environment, whether or not they are a family member" (p.6).

Despite increasing social and professional awareness, Pereda et al (2009) note that epidemiological studies on child sexual abuse remain few and far between, and tend to lack methodological rigour. Few incidence studies (for example, the number of cases of child sexual abuse over a given time period) have been conducted, and the secrecy that very often characterises the dynamics of abuse means that official statistics on child sexual abuse are likely to represent a significant underestimation of the size of the problem. Prevalence studies (for example, retrospective studies of the number of people reporting sexual abuse in their childhood) are more common. Pereda and colleagues (2009) conducted a meta-analysis of 100 prevalence studies spanning more than 20 countries and concluded that, overall, 7.9% of men and 19.7% of women globally have experienced some form of sexual abuse prior to the age of eighteen.

In their UK prevalence study, Radford and colleagues (2011) found that 10.8% of their random probability sample of over 6,000 respondents reported unwanted sexual exposure in childhood, and 5% of all respondents had experienced coerced sexual acts under the age of 16. Reports of sexual abuse by a parent or guardian were low, but where this was reported, most experiences included contact sexual abuse. Conversely, of those respondents who reported contact sexual abuse, in two thirds of cases (65.9%) the abuse had been perpetrated by someone under the age of 18. The more recent Children's Commissioner for England's Inquiry (2015) found that 25% of all cases of child sexual abuse in the family environment involved a perpetrator under the age of 18 years old. Approximately a quarter of all respondents to the Inquiry's survey of adult survivors stated that they did not realise that they had been abused until they reached adulthood. Overall, the Inquiry estimated that only one in eight victims of child sexual abuse in the family environment come to the attention of the statutory authorities, with abuse by a family member in itself representing a barrier to victims accessing help.

1.2   The effects of child sexual abuse

The experience of sexual abuse is associated with a complex range of psychological and behavioural symptoms in both childhood and adulthood (Berliner & Elliott, 2002; Putnam, 2003). In their meta-analysis of the published research on the effects of child sexual abuse, Paolucci and colleagues (2001) found a substantial effect of child sexual abuse on post-traumatic stress, depression, suicide, sexual promiscuity, sexual perpetration and academic achievement. While some researchers have suggested that the severity of the impact of child sexual abuse is associated with 'abuse-specific' variables, such as the chronicity and recency of the abuse and the relationship of the victim to the perpetrator (Trickett et al, 1994), the mediating effect of such abuse-specific variables is disputed. Paolucci and colleagues

(2001) found that gender, socioeconomic status, type of sexual abuse, age when abused, relationship to perpetrator and number of incidents of abuse did not mediate the effect of the child sexual abuse on outcomes.

In contrast, some studies have emphasised the importance of contextual and environmental factors on outcomes for sexually abused children (Skuse et al, 1998). These include a range of important 'distal' factors, such as the nature of the child's early attachment experiences, early exposure to domestic violence and parental mental ill–health, care history and placement stability, and the presence of a non-abusing carer who believes and supports the child following disclosure (Tarren-Sweeney, 2008). Additionally, the negative impact of child sexual abuse appears heightened when the child's experience of sexual abuse occurs within the context of other forms of victimisation and trauma; a concept that Finkelhor and colleagues have termed 'polyvictimisation' (Finkelhor, Ormrod & Turner, 2007). In the NSPCC UK prevalence study, Radford and colleagues (2011) found strong associations between experiences of sexual abuse and physical violence and poorer emotional wellbeing, including self-harm and suicidal thoughts. Children abused by a caregiver also faced increased risk of being abused or victimised by others inside and outside of the family (Finkelhor, Ormrod, Turner & Holt, 2009). Radford and colleagues (2011) concluded that children and young people who are 'polyvictims' are an extremely vulnerable group who need early identification and intervention in order to prevent both intervention and longer-term problems.

1.3 Research on the effectiveness of therapeutic interventions for children affected by sexual abuse

There have been two Cochrane systematic reviews of the effectiveness of therapeutic interventions published in the last few years. The first (MacDonald et al, 2012) identified 10 studies of cognitive behaviour therapy (CBT), published between 1996 and 2004. All but one of these had been conducted in the USA and five had been conducted by essentially the same research group. The exception was a small-scale study that derived from Australia. All these studies required independent substantiation that participants had experienced contact sexual abuse. Overall, the studies recruited from a wide age range (two to 17), but most focused on children between seven and 14 years old, around half of whom had experienced actual or attempted penetration. Most children had been abused by men whom they knew and the majority of abusers were family members. The number of abusive incidents varied considerably within most studies.

Three of the 10 studies offered group-based interventions and the remainder provided individual CBT. The control group in four studies was a non-directive, supportive therapy. Three compared CBT with or without a carer intervention and the others used community 'treatment as usual' or a waiting list control.

The Cochrane reviewers were quite critical of the quality of the published studies. Thus, only four studies were judged to have a 'low risk of bias' in the randomisation process, and most reported results only for those who completed therapy ('completers') and failed to report reasons for exclusions and drop-outs. Further, from a statistical perspective, all but three of the studies were probably underpowered and because they were single-site studies, generalisability was restricted. The three largest studies had over 100 participants. The 'benchmark' study by Cohen et al (2004) was the largest of all and involved 229 children and 189 carers in two children's hospitals in the United States. Children and carers each received up to 12 sessions of CBT or 'child-centred therapy'. The researchers excluded from the analysis children who attended fewer than three therapy sessions. Altogether, 180 children (79%) completed follow-up (Time 2) measures. The researchers used a recognised statistical procedure to impute missing data and employed an 'intention to treat' analysis in addition to an effectiveness analysis of outcomes for children who completed therapy.

Considering the outcomes of all the 10 studies, the Cochrane review concluded that "…CBT may have a positive impact on the sequelae of child sexual abuse, although most results were not statistically significant. Strongest evidence for positive effects of CBT appear to be a modest reduction in depression, PTSD and anxiety symptoms" (MacDonald et al, 2012, p.16). Children in Cohen et al's study who received CBT demonstrated moderately better improvements for depression, PTSD and behavioural problems compared with those who received child-centred therapy, but children in both groups improved.

There is little or no evidence to support the use of other therapeutic approaches; the Cochrane review of psychoanalytic/psychodynamic psychotherapy for child sexual abuse failed to find a single study that met their inclusion criteria (Parker & Turner, 2014). However, in the only previously published randomised trial in the UK, Trowell et al (2002) found that both individual and group psychotherapy for sexually abused girls was effective, with a somewhat greater improvement in post-traumatic stress.

1.4 Letting the Future In: Brief account of origins and development

In 2009, the NSPCC commissioned two evidence reviews. The first estimated the demand for therapeutic services for children affected by sexual abuse in the UK by comparing existing estimates of the prevalence of child sexual abuse with a mapping exercise of the number and type of therapeutic services available. This revealed that, while approximately 16,000 children and young people were in receipt of a service in 2006–07, the *need* was estimated to be over 70,000 (Allnock et al, 2009). The second review focused on the existing evidence of the effectiveness of therapeutic interventions for child sexual abuse (Allnock & Hynes, 2011).

Both reviews fed into the development of *Letting the Future In* (LTFI). Trish O'Donnell, Development Manager for sexual abuse at the NSPCC, brought together a group of four NSPCC practitioners experienced in working with child sexual abuse from a range of practice backgrounds including social work, as well as play, family and systemic therapy. This internal group was initially joined by four external experts who, together with the development manager and the researcher who led on both reviews, began to meet regularly to develop the practice guide (the external experts eventually dropped out of the process). In this way, the guide was developed using a mix of practice experience and the evidence review.

The group made some early, key decisions in scoping the remit of the guide. Initially, the intervention was intended to be based on Cognitive Behavioural Theory (CBT) because of its strong evidence base, but the group felt firmly that this would exclude too many children for whom this approach was unsuited. They also wanted the intervention to be suitable for a wide age range and settled on 4–17 years. More controversially (within the group), children with learning disabilities were excluded, although a separate intervention has since been developed for this group of children. Both the review and practitioner experience pointed towards an intervention that had a high-quality initial assessment, was centred on the development of a strong therapeutic relationship, could draw on elements of different therapeutic approaches to enable practitioners to respond to individual need and preferences, and would attend to the needs of the carer as well as the child.

The initial version of the guide was piloted by one NSPCC team in the first instance. It was quickly widened to a six-team pilot before being rolled out across England, Wales and Northern Ireland later the same year. It is acknowledged by the development manager that finalising the practice guide and the development of training for

practitioners was somewhat of a rushed process. The NSPCC was committed to evaluating the guide from the start (and indeed had been funded to do so) and the evaluation team were commissioned towards the end of the initial pilot as the guide was rolled out to 18 NSPCC teams.

1.5 Theoretical components

Historically, practitioners in the NSPCC emphasised the use of creative therapies in their work with children and young people of all ages. LTFI builds on this tradition, with the framework based upon a revised version of Bannister's (2003) *Recovery and Regeneration Model*. Bannister's model has not been empirically tested. It is influenced heavily by the principles and approaches used in psychodrama (Moreno, 1983), play therapy (Gil, 1991) and attachment theory (Bowlby, 1969). Bannister describes three phases to her regenerative approach. Assessment is based on an understanding of the child's developmental needs and the ways in which sexual abuse may interrupt the process of development, as demonstrated in the child's projected play. Bannister then describes an action phase whereby a positive relationship is built through the therapeutic exchange with the worker, focusing on acceptance, boundary development and confirming the child's feelings and identity. The worker uses creative techniques such as interactive play, drama, art, stories and role reversal. In the third stage, the focus shifts to resolution, with the worker encouraging the child to better understand and express feelings, and to develop self-awareness and relationships. Bannister's approach is largely psychodynamic in nature and emphasises the therapeutic attunement of the worker to the child's affective states (Stern, 1998). The therapeutic relationship formed between the worker and child is, therefore, seen as the core means through which therapeutic change is generated.

While influenced by Bannister's model, at the same time LTFI is deliberately multi-theoretical, using diverse constructs to build: a **value base**; an underpinning **knowledge base**, including of core theories of child development and developmental milestones, attachment theory, vulnerability and resilience factors, Finkelhor and Brown's (1986) traumagenic dynamics model of the impact of sexual abuse and the effect of trauma on brain development; and a **skills base**, including the use of the therapeutic relationship, motivational interviewing (Miller & Rollnick, 2002), Howes' trauma model approach, creative therapies and the use of symbolic play (Axline, 1964) and Trauma Focused CBT (Cohen et al, 2010). The guide recognises that The National Institute for Health and Care Excellence (NICE) currently recommends CBT as a first-line treatment for

symptoms associated with sexual abuse. However, the guide states that CBT will not be suitable for all children, for example very young children, and that older adolescents may prefer a different style of treatment to a talking therapy. In terms of the theoretical components, the guide suggests that it intends that each child is approached with a truly open stance, with workers using a range of theories, models and approaches in order to provide a response that is best suited to the child's specific learning style, defence mechanisms, gender, culture and developmental stage.

The importance of work with non-abusing carers in the treatment of children who have been sexually abused has long since been recognised (Glaser, 1991). The core LTFI theoretical model, Bannister's (2003) Recovery and Regeneration Model, does not provide a specific theoretical basis for the carer intervention. However, Module Two of the guide makes it clear that Bannister's ideas can be complemented by those from Trauma Focused CBT (TF-CBT) (Cohen et al, 2004). The areas listed as relevant for LTFI from TF-CBT include psycho-educative work, the development of parenting skills and the use of conjoint child–carer sessions. Theoretically, the guide therefore sees work with carers primarily as a means of supporting the child, rather than as therapy for the carer. The guide (Module 2, p.82–82) suggests that the carer intervention is designed to equip safe carers to:

- Process the impact of discovering the child's sexual abuse;

- Create a social environment that facilitates their children's recovery;

- Provide emotional warmth alongside structure and routine;

- Help their child feel safe; and

- Collaborate in the process of their child in re-authoring their trauma narrative.

This work with the safe carers is also seen as part of the agency's concern to safeguard children from further abuse and to promote their welfare.

1.6 The intervention guide

It is important to highlight that LTFI is described not as a manual or a manualised intervention, but as a guide that is to be used adaptively by practitioners. The guide offers clear inclusion criteria and an overall structure to the work, but within this overarching structure, practitioners have considerable freedom to use the resources and materials in the guide flexibly.

The guide is designed for work with children and young people who have experienced sexual abuse and who are aged between four and 17 years at the time of referral. It is offered only to children who are living with a carer who has been identified as a 'safe carer' and where the child is not living with the alleged adult perpetrator of the sexual abuse. If a child is living with a sibling perpetrator at home, a satisfactory safety plan must be in place before the child can access LTFI. The child's placement must be assessed as stable, with no planned moves, and the child must be in agreement with the referral to the service. The full criteria for the intervention are set out below in Section 2.1.2.

1.6.1 Assessment

Access to the therapeutic intervention is based on a two-stage assessment. First, a **referral assessment** acts as an initial information gathering stage so that, as far as possible, practitioners can make an informed judgement on the suitability of the referral before expectations are raised with the child and carer. Permission is sought from the carer and older children for the practitioner to contact other agencies, where necessary, for information to add to that which has been given at referral. Once information has been gathered, the practitioner discusses the referral with the child's main carer or the child directly if the child is of sufficient age. The practitioner will also aim to determine whether or not the non-abusing carer is able to offer a satisfactory level of protection and support for their child during the intervention. Safeguarding issues are discussed explicitly with the carer.

If there are no contra-indicators, the non-abusing carer is deemed to be a safe carer for the purposes of the intervention and the worker moves to the second assessment stage, namely the **assessment of therapeutic need.** Here, the worker uses a standardised self-completion measure of trauma appropriate to the age and comprehension of the child. Two measures were developed by Briere in the United States (Briere, 1996; 2005) for use in psychological assessment and for research. For children eight years and above, this is the Trauma Symptoms Checklist for Children (TSCC). For younger children, the carer completes the Trauma Symptoms Checklist for Young Children (TSCYC) on the child's behalf[2]. In total, the guide specifies 2–4 assessment sessions with the child in total and 1–2 with the carer. The worker completes an assessment report, which provides an analysis of the child's and carer's needs in relation to the LTFI intervention and formulates recommendations. Alternatively, if it has

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2   This procedure was amended for the purpose of the randomised controlled trial (RCT) that was used to evaluate the intervention. All cases accepted for the study completed the TSCC/TSCYC at or soon after the first home visit, prior to randomisation and (for those in the intervention group) proceeding further with the assessment.

been deemed that the intervention is not appropriate, the assessment report specifies the reasons for not progressing to the intervention. A review meeting is held with the child and carer in order to share the report and its recommendations.

1.6.2 Intervention

As a consequence of the completed assessment, the worker should compile an intervention plan using a template included in the guide. Children may then receive up to 20 face-to-face weekly sessions using the range of theories and methods as discussed in the preceding section. Usually, sessions are offered in the NSPCC service centre but if this is not possible for the child, an alternative safe neutral space can be used. The guide provides examples of sessions focusing on:

- Socio-educative work
- Sexually inappropriate behaviour (where relevant)
- Power relationships
- Helping the child become aware of their emotions and manage feelings
- Self-esteem and identity
- Integrating traumatic experiences

Progress is reviewed, including re-administering the TSCC/ TSCYC after an appropriate interval if necessary. Endings are planned for after the 20 sessions. However, if it is agreed that more intervention is required to meet the needs of the child, the guide specifies that 10 more sessions may be offered to the child.

A maximum of eight face-to-face sessions are also offered to safe carers by a practitioner not directly involved in the direct work with the child. The guide does not explicitly identify this work as therapeutic, but the emphasis is stated to be on socio-educative work with the aim of helping carers to support the work being offered to their child. As such, the suggested interventions cover the following topic areas:

- Helping the carer express and process the personal impact of discovering that their child was sexually abused;
- Educating carers about the nature and consequences of sexual abuse;
- Helping carers consider how they can support their child;
- Assessing the safe carer's capacity for joint sessions; and
- Preparing for joint sessions with the child/young person and the safe carer.

If it is deemed in the child's best interests, up to three joint sessions may be held between the safe carer and the child, facilitated by the child's worker. The content of these joint sessions should either provide socio-educative messages or they must help to build and repair the relationship between the carer and child.

The final module in the guide focuses on resolution and the end of therapy. The guide provides a phase three template from the revised Bannister regenerative model and an agreed ending plan is put in place. One face-to-face session to effect the ending is offered.

1.7 The research questions

The research questions concerned the implementation of LTFI in NSPCC teams (the process evaluation) and its outcomes (the impact study).

The impact evaluation asked the following questions:

1. What are the outcomes for children and young people affected by sexual abuse of providing LTFI delivered by NSPCC service centres?

2. What is the cost-effectiveness of this service[3]?

3. What is the effectiveness of the support intervention received by the 'safe carers'?

The full methodology for the impact evaluation is set out in Section 2 below.

The process study asked:

4. How is *Letting the Future In* delivered?

5. What are children's, safe carers' and practitioners' experiences and perceptions of the intervention?

The full methodology for the process evaluation is set out in Section 8 below.

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3   The cost effectiveness study is still proceeding and will be reported in a subsequent publication.

2. Impact evaluation

2.1 Method

2.1.1 A pragmatic randomised trial with waiting list control

The first research question on impact concerned the outcomes for children of providing LTFI in NSPCC service centres. Following extensive discussion with NSPCC staff (detailed in Jessiman, Carpenter & O'Donnell, 2016), the impact evaluation was designed to use the most rigorous methodology possible, a randomised controlled trial (RCT). This was a 'real world' or 'pragmatic' trial in that it evaluated an existing service rather than a clinical trial of a service set up specifically to test the effectiveness or comparative effectiveness of particular therapies. In contrast to clinical trials, participants in a pragmatic trial are not carefully selected to meet set diagnostic criteria and for their motivation for the intervention; and the therapists are not drawn from a group of specially trained practitioners working closely to a manual. Instead, the eligibility criteria were broadly defined because the NSPCC offers an inclusive service and the children's services practitioners (CSPs) providing it were unselected and had varying levels of experience and training; the intervention itself was applied flexibly, as it would be in routine practice. In other words, the trial involved participants, both children and practitioners, who are like those for whom the intervention is intended in the real world of services.

While clinical trials generally involve a comparison between two or more interventions, pragmatic trials usually involve a comparison with 'treatment as usual'. In this case, as the NSPCC survey of sexual abuse services found, there is no such 'usual' treatment and in many parts of the UK there is no service at all. The research question was not whether LTFI was superior or inferior to another therapy for child sexual abuse, such as CBT. LTFI had not previously been tested and the research team took an open-minded position ('equipoise') on whether or not it might make a difference (for good or bad). In these circumstances, a 'waiting list controlled' trial is most appropriate.

The logic of the waiting list controlled design is straightforward: having been assessed for eligibility, children and their carers complete baseline measures and are then randomised to either an intervention group or a waiting list group. After a defined period, six months in this case, the children and carers in both groups were re-administered the measures and the outcomes compared. The research hypothesis is that children receiving the intervention will improve and those on the waiting list will stay the same or get worse. If there are

differences between groups, this may be attributed to the effects of the intervention.

All children were followed up six months later. This enabled us to see whether any changes in the intervention group have been maintained and whether or not those children who have been on the waiting list changed after receiving their intervention. Unlike in a comparative trial of different treatments, this follow-up did not allow us to compare the longer term outcome in two groups and this is the most obvious limitation of the design.

Evaluations using RCTs are often criticised because they do not explain what happened to the children and families who participated in the intervention. It is important to remember that LTFI is a guide to practice rather than a detailed protocol for treatment, as used in most studies of the effectiveness of interventions. Such studies specify not only the number of therapy sessions to be delivered over a particular time period and who should receive them, but also the specific interventions to be used in the sessions. By contrast, LTFI specified only the total number of sessions for children and safe carers respectively, as explained previously in Section 1.6 above and there was no fixed time interval between sessions. There was also no minimum 'treatment package' to which the families were required to commit; children and/or carers were able to cease attending if they wished, with or without the agreement of their practitioners. Likewise, the practitioner, with the agreement of the team manager, could decide not to offer a service following the therapeutic assessment and/or to refer to another service. Consequently, the first step in an analysis of the impact of LTFI was to understand how LTFI was actually delivered in practice by asking the practitioners to record systematically the interventions from the guide that they used in each session.

There is another important feature of the design. Because the primary aim was to assess the effectiveness of a service, all children referred to it were included in the analysis of outcomes, whether or not they dropped out or even attended any therapy sessions. This is known as an "intention to treat" analysis. By including children who did not engage with the services or who dropped out of LTFI early, the intention to treat analysis addressed the question about the effectiveness of a service and not just its efficacy for those children who completed the intervention. As noted in the review of previous studies in Section 1.3, this was the approach used by Cohen and colleagues (2004) and is consistent with CONSORT guidelines on the conduct of RCTs because it reduces a significant source of bias (Moher et al, 2010). Given the substantial size of their sample, Cohen and colleagues were able to use a robust statistical technique known as multiple imputation to estimate missing scores and substitute these

in the data set for analysis. In the LTFI evaluation, this analysis drew on potentially important contextual data about the other forms of victimisation experienced by the children, as well as demographic and child sexual abuse-related variables for the data imputation.

Like Cohen and colleagues, we first report the results for 'Analysis Completers'– those cases in both the intervention and waiting list control groups for which we have complete data at baseline (T1) and six months (T2). Analysis Completers may or may not have completed the *intervention*.

The effectiveness or otherwise of the LTFI intervention itself is also of interest and, consequently, an analysis of the outcomes for children and their carers who actually engaged in the service was planned. Engagement was defined by the NSPCC as having attended four or more assessment and therapy sessions. The statistical analysis is based on completers. Note that this was the sole approach taken by most of the CBT studies in the Cochrane Review. We refer to this as the 'effectiveness' analysis.

2.1.2 Study inclusion and exclusion criteria

Because this is a pragmatic trial, the inclusion criteria for the trial reflected the inclusion criteria for the service. These were that the child:

- has made a disclosure, and experienced sexual abuse as established by either: a joint police and social services investigation; by single police investigation only; or in exceptional cases where the child is of sufficient age and understanding as to withhold a formal statement to the police, but children's social care are aware of the allegation, which is believed and protective action has been taken because of it;

- is aged between four and 17 years on referral;

- has no diagnosed learning disability;

- has the ability to communicate without an intermediary;

- is living with a carer who has been identified as safe;

- is not living with the alleged adult perpetrator (if sibling perpetrator remains in the home, a satisfactory safety plan is in place, which includes victims' views);

- is in a stable placement and there are no planned moves; and

- is aware of and agrees to the referral.

For inclusion in the RCT, both the child and safe carer must give consent to the evaluation (non-consenting cases were still randomised, but excluded from the study).

Exclusion criteria pre-randomisation: Children were excluded from the intervention and, consequently, the trial if the baseline assessment on the TSCC or TSCYC at T1 indicated that a child was affected by a serious mental health issue, such as psychosis or suicidal intent. In such cases, children were referred on to alternative NHS services for assessment and treatment and not entered into the trial.

If there were any other indicators that the child was in need of urgent intervention, either from referral data or meeting the child at the initial eligibility assessment, they could be excluded from the trial. NSPCC guidance states that while LTFI is not a crisis intervention, there may be exceptional circumstances where the child should be seen immediately. Examples of this included where delay to intervention would put a looked-after child's placement as risk. Such decisions were at the team manager's discretion in consultation with the NSPCC senior management team.

Siblings of children already in the trial were excluded because it would have been unethical to provide (or postpone) the intervention to one child and not the other. Siblings were, in effect, allocated to the same condition, but their data was not included.

Exclusion criteria post-randomisation: If further information came to light, a child could be excluded. One reason would be new disclosures of abuse, in which case a child could be referred back to the police or social services for investigation. Another would be if a child's placement turned out to be unstable. If the child experienced a significant deterioration in circumstances while on the waiting list, the team manager could consider the child for intervention and not wait for the remaining period.

2.1.3 Defining outcomes

The primary outcome was the change in the proportion of children with **clinical** levels of symptoms or problematic behaviour or **significant difficulties** from initial assessment at referral to the service to six months later (in other words, the proportion of children with symptoms who had got 'better' or 'worse').

Specifically, this was assessed using a validated self-report questionnaire, the Trauma Symptoms Checklist (TSCC) (Briere, 1996) for the older children and, for younger children, the Trauma Symptoms Checklist for Young Children (TSCYC) (Briere et al, 2001), which is completed by a parent or carer. These measures are standardised and produce a set of scores adjusted for gender and age in relation to scale norms. This enabled us to compare the proportions of cases above/below the 'clinical' and 'significant difficulty' thresholds at baseline (T1) and follow up (T2 and T3) for the intervention and waiting list control groups.

The secondary outcome for the child is the change in mean scores on the TSCC or TSCYC subscales for all children in each group, including those who did not have clinical levels of symptoms or problems at baseline. As we have noted in the review of the effects of child sexual abuse, not all children show evidence of symptoms of problematic behaviour.

The other secondary outcome was for the carer. This was changes in parental stress and feelings for the child measure over the six months by a validated instrument (The Parenting Stress Index) (Abidin, 1995).

2.1.4 Sample size and statistical power calculation

As noted previously in Section 1.3, most previous outcome studies had small samples and were probably statistically 'underpowered' and the findings not generalisable because they came from only one site. We therefore carried out a statistical power calculation in order to estimate the sample size that would be required to detect a causal effect of the intervention when such an effect truly exists. This calculation was based on an analysis of a previous NSPCC data set using the main outcome measure, the TSCC, and the research design.

The design is technically a person–randomised trial in multiple sites with a repeated series of continuous measures for children. Because the children were recruited from many NSPCC sites, this is an example of a 'two-level' trial with one level of randomisation (children are initially randomly assigned to the intervention or waiting list control group). In order to have sufficient power (greater than or equal to 80%) to detect a 'medium' effect size (Cohen's d= 0.4) for the difference in outcomes between intervention and waiting list control groups with $p<0.05$, we required an estimated sample of 210 respondents.[4]

All 20 NSPCC service centres in England, Wales and Northern Ireland providing LTFI during the study period were potentially eligible to participate in the evaluation once their staff had attended a one-day training in the evaluation design and procedures, including the use of the research instruments. The teams could join the RCT once the number of cases was close to the capacity of the team to provide a service. At this time, cases could be randomly allocated to intervention or the waiting list. In total, 18 of the 20 teams were able to join the trial for all or part of the 18-month recruitment period (May 2013 to November 2014). The teams were of different sizes and thus had different capacities for cases. They also varied in the time

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4   The required sample size was calculated using *Optimal Design* software from the University of Michigan: Raudenbush, S. W., et al (2011). Optimal Design software for multi-level and longitudinal research (Version 3.01) [Software]. Available from https://sites.google.com/site/optimaldesignsoftware/home

they joined the trial and two of the teams had to drop out because of staff shortages or, conversely, overcapacity. The mean number of RCT cases per team was 13.4 (range 1 to 42).

2.1.5 Randomisation

Randomisation was managed remotely by a computer software programme (TENALEA) in a clinical trials centre in the Netherlands. It happened case-by-case across all the 18 NSPCC teams who participated in the trial and was done in blocks of four (for example, two cases in four were allocated to the intervention and waiting list control groups) so that allocation was fairly balanced throughout the recruitment period. This meant that it was impossible for either NSPCC staff or the research team to predict the likely sequence of randomisation, thus eliminating an important potential source of bias. The eligibility criteria, allocation procedure and exceptions to the protocol were all detailed in an evaluation handbook held by each team.

2.1.6 Potential sources of bias

All measures were based on self-report or proxy-report (by the safe carers). The outcome measures (TSCC and TSCYC) include items to identify possible under- and over-reporting of symptoms.

No independent external assessment was possible within the resources of the study and this would not have been approved by the research ethics committees. The self-completion questionnaires were administered to the participants by NSPCC staff during the referral assessment and again at the two follow-ups. In order to reduce potential performance bias, the follow-up assessments were undertaken by a team member who had not worked with the child or carer, but this person would have been aware that this was a follow-up. Potential sources of selection bias were eliminated by using a true, independent random sequence generation and a concealed allocation procedure, described above. Attrition bias was reduced by using statistical imputation procedures for drop-outs from the study.

The study was registered with the ISRCTN Register, the World Health Organisation's primary registry for the UK (study no. ISRCTN65340805).

2.1.7 Research ethics approval

The study design and procedures were approved by the independent Research Ethics Committee of the NSPCC and the Research Ethics Committees of the Universities of Bristol and Durham. The committees stipulated that participants, both children and adults, should not be unduly burdened by the data collection process. Consequently, baseline data was collected by trained NSPCC practitioners as part of the referral assessment, rather than by research staff, so that they were not asked the same questions twice. (Assessment by research staff would not have been possible logistically given the wide dispersion of the teams.)

2.2 Participants

2.2.1 Demographics

 Once an NSPCC team entered the RCT, all referrals accepted for service were randomised prior to service regardless of whether they consented to take part in the research. This was to eliminate a possible perverse incentive not to take part in the trial because they might avoid the waiting list. There were only 26 cases (9%) where the children (or their safe carers) did not give consent to take part in the research; the numbers were similar in both intervention and control groups. The 242 remaining children were randomly allocated to the intervention or waiting list control group. As shown below in the CONSORT flowchart in Figure 1, nine children (7%) were removed from the waiting list according to study protocol to safeguard children at risk. Teams were advised that if a child experienced significant deterioration in circumstances while on the waiting list, the team manager could consult the regional service lead and consider the child for immediate intervention and/or referral to another agency and remove them from the waiting list. In four cases, the child's family were due to be moving from the area before the waiting list period elapsed or they were in foster placements. Three cases were referred to the police or child protection services because they were at risk of further abuse. Two cases were removed following randomisation because of serious risk of self-harm. Four waiting list cases were randomised in error, one was over-age and three already had siblings in the trial. In total, valid baseline (T1) data was collected from 128 children in the intervention group and 114 in the waiting list group. Full details are in Figure 1 below.

There was significant attrition (a loss of 71 cases, 29%) between the baseline and six-month follow up, split almost equally across the intervention and control groups. In the intervention group, the majority of 'lost' cases (26) was due to the child disengaging and either declining further consent, or NSPCC staff making a clinical decision that it was not in the child's best interest to re-contact for data collection. Six cases were referred to another service. There were two protocol errors. Of the waiting list group, most attrition was due to the child (or safe carer) declining the intervention after the waiting period and also withdrawing from the study n=17). The NSPCC decided not to offer the service in five cases and failed to achieve contact in another five cases, with a further two families having moved away. A further six cases were removed from the waiting list and offered immediate service due to deteriorating circumstances.

The attrition of cases between the six- and 12-month follow up was larger in the immediate intervention group. At this stage, many children in this group would have completed their intervention and would no longer be in contact with the NSPCC, while children placed on the waiting list would have mostly been mid-intervention. Again, full details are in the CONSORT diagram; note that 'protocol error' in most cases meant that data collection at 12 months was simply missed by teams, although reminders had been sent.

The demographic profile of the children and young people who met the eligibility criteria and agreed to take part in the evaluation is shown in Table 1 below. Almost three-quarters of the participants were girls, which was very similar to the Cohen et al study (2004), and the mean age was identical, although the age range was larger (six to 16 here) compared with eight to 15 in Cohen. That study had a much higher proportion of black and minority ethnic children (39%).

As will be explained later, the age *and* cognitive ability of the child or young person determined the appropriate primary outcome measure used in the study. In Table 1 below we refer to 'older children and young people' and 'young children' when considering the outcome group. The first group comprised two thirds of the participants, generally aged eight to 17 and judged able to complete self-report measures. The young children group, comprising children aged three to seven plus children over eight judged unable to complete the self-report measure, accounted for the other third. Note that the younger children in the waiting list group were more likely to have been excluded from the trial after randomisation.

Table 1: Demographics of children participating in the trial

	Intervention n=128		Waiting list n=114		Total n=242	
Age at T1	Mean (yrs)	SD	Mean (yrs)	SD	Mean (yrs)	SD
	10.7	3.8	10.8	3.6	10.7	3.7
Outcome group	n (%)		n (%)		n (%)	
Older children and young people	82		80		162 (67%)	
Young children	46		34		80 (33%)	
Gender	n (%)		n (%)		n (%)	
Male	32 (25)		31 (27)		63 (26)	
Female	96 (75)		83 (73)		179 (74)	
Black and Minority Ethnicity[a]	10 (8)		12 (11)		22 (9)	
One or more disabilities	19 (15)		23 (20)		42 (17)	
Looked after child	14 (11)		14 (12)		28 (12)	

[a] Children of Black and Minority Ethnic backgrounds included African (5), White and Black Caribbean (3), other Black background (4), Indian (1), Pakistani (1), Caribbean (2), White and Asian (4), other mixed background (2).

There were no statistically significant differences between children in the intervention and control groups.

Figure 1: CONSORT flowchart for children in the RCT

Follow-up (T2)

Intervention	Waiting List
Lost to follow-up (n=36)	**Lost to follow-up (n=35)**
Discontinued intervention before T2 (n=26)	**Removed from Waiting List:**
Child disengaged and declined further consent (n=16)	Cases in crisis and received intervention – removed according to protocol (n=6)
Child disengaged and clinical decision not to re-contact for T2 data (n=10)	**Did not return to service after W/L period and no data collected (n=29)**
Protocol error (wrong measure used) (n=2)	Family moved out of area (n=2)
Case closed by team:	Family declined service (n=17)
Following therapeutic assessment, service not needed and not followed up **(n=2)**	NSPCC decision not to offer service (n=5)
Referred for another service **(n=6)**	No contact achieved (n=5)
NSPCC service (n=2)	
External (police/ children's services/ CAMHS) (n=4)	

Analysis (T2)

T2 data completed (n=92)	**T2 data completed (n=79)**
T1/T2 data available 92/128 (72%)	T1/T2 data available 79/108 (73%)
Included in ITT analysis (n=128)	**Included in ITT analysis (n=108)**
	Excluded (n=6)

Follow-up (T3)

Lost to follow-up (n=43)	**Lost to follow-up (n=30)**
Child disengaged and clinical decision not to re-contact for T3 data (n=3)	Child disengaged and clinical decision not to re-contact for T3 data (n=2)
Child disengaged and declined further consent (n=6)	Child disengaged and declined further consent (n=2)
Declined consent to complete evaluation (n=2)	Declined consent to complete evaluation (n=2)
Family moved out of area (n=2)	Family declined service (n=4)
No contact achieved with family (n=8)	Family moved out of area (n=2)
Protocol error by team (n=22)	No contact achieved with family (n=3)
	Protocol error by team (n=15)
	Re-joined trial (n=2) Data missing at T2 but do have T3 data

Analysis (T3)

T3 data completed (n=49)	**T3 data completed (n=51)**

2.2.2 Nature of sexual abuse and abuser

As sexual abuse exists in many forms, and as some researchers have found that the severity of the impact of sexual abuse varies according to abuse type (Trickett et al, 1994), it was important to be able to identify the range of abuse types that children in the sample had experienced. Practitioners were asked to complete a Case Descriptor Record on case closure to record information about the nature of the abuse experienced by the child, and demographics of the perpetrator(s). Five non-mutually exclusive categories were described: non-contact abuse, online sexual abuse, inappropriate touching, penetrative/attempted penetrative abuse and violent sexual abuse. Practitioners were asked to identify all forms of abuse that any given child receiving LTFI had experienced.

Table 2 shows children's experiences of sexual abuse in both the intervention and control groups, while Table 3 shows the same information for both young children, and older children and young people. The overwhelming majority of the children and young people accessing LTFI had experienced contact sexual abuse comprising inappropriate touching or penetration. There was no significant difference in terms of types of abuse experienced between intervention and waiting list control group. In a review of 46 studies of the impact of sexual abuse, Kendall–Tackett and colleagues (1991) found that abuse that contained some form of penetration was more likely to produce symptoms than non-penetrative abuse. Likewise, a small number of children receiving LTFI experienced sexual abuse accompanied by gratuitous violence, with violent sexual abuse comprising only 3.5% of the overall abuse experienced. Use of physical violence and force in the commission of sexual abuse is at the extreme end of a continuum of sexual abuse and has been demonstrated as a factor that can also lead to increased symptomatology (Kendall–Tackett et al, 1991).

Although online sexual abuse of children is an area of developing concern for professionals, only a small number of children receiving LTFI had been abused in this way. It could be that some children with this experience were referred to services specifically dealing with online safety and abuse (where these exist), rather than the LTFI intervention.

The relationship between the perpetrator and the child has also been identified as a factor that could influence the impact of sexual abuse. Kendall–Tackett and colleagues (1991) concluded that a perpetrator who is close to the victim causes more serious effects than one who is less close. As a result, although acknowledging the broader definition of 'child sexual abuse within the family environment' proposed by the recent Inquiry report (Children's Commissioner, 2015) (and as discussed in previously in Section 1.1), we nonetheless wished to examine distinctions between children who had been sexually abused by a family member (which we refer to as 'intra-familial' sexual abuse) and those whose abuser was not a member of their family (which we refer to as 'extra-familial' sexual abuse). Thus, our definition of intra-familial and extra-familial child sexual abuse differs from that of the Children's Commissioner's Inquiry report, but is in line with those offered in the classic and influential work of Russell (1983), who defined intra-familial child sexual abuse as "any kind of exploitive sexual contact…between relatives, no matter how distant the relationship" (p.135) and extra-familial child sexual abuse as "one or more unwanted sexual experiences with persons unrelated by blood or marriage" (p.135) under the age of 18.

Children receiving LTFI were almost twice as likely to have been abused by someone in their family as by someone outside it, and many abusers who were not family members could still have been known to the children. Children in the intervention group were significantly more likely to have been abused extra-familially than those in the waiting list control group (42% vs 28%). However, the two groups did not differ on the number and age of perpetrators. Most had been abused by a single perpetrator, though in 12% of cases where the number of perpetrators was known, children had been abused by two or more perpetrators. Four in 10 known perpetrators of the sexual abuse were young people under the age of 18. This is a higher rate of child perpetrated sexual abuse than recorded in official statistics. Reviewing the pattern of criminal statistics over a period of a decade, Hackett (2004) estimated that between one fifth and one third of all child sexual abuse in the UK involves other children and adolescents as perpetrators. An overview of sexual offending in England and Wales published by the Ministry of Justice (2013) highlighted that of 5,977 offenders found guilty of sexual offences in 2011 in England and Wales, 491 were under the age of 18 (for example, 8.2% of all convictions).

Table 2: Children's experiences of sexual abuse (Case Descriptor Record) (N =223/242 [92%])

	Intervention		Waiting List		Total	
Mean age of child at onset of sexual abuse	**Mean (yrs)**	**SD**	**Mean (yrs)**	**SD**	**Mean (yrs)**	**SD**
	6.9	4.64	6.9	4.82	6.9	4.71
Age group of child at onset of sexual abuse	**n (%)**		**n (%)**		**n (%)**	
Less than 3 years	22 (19)		22 (21)		44 (20)	
3–7 years	47 (40)		38 (37)		85 (38)	
8–12 years	34 (29)		25 (24)		59 (26)	
13+ years	16 (13)		19 (18)		35 (16)	
Total	119		104		223	
Nature of sexual abuse (includes multiple forms of abuse per child)	**n (%)**		**n (%)**		**n (%)**	
Non-contact	18 (16)		9 (9)		27 (12)	
Online sexual abuse	5 (4)		4 (4)		9 (4)	
Inappropriate touching	75 (65)		68 (66)		143 (66)	
Penetration or attempted penetration	55 (48)		53 (52)		108 (49)	
Sexual abuse accompanied by gratuitous violence	2 (2)		10 (10)		12 (5)	
Number of known incidents of sexual abuse	**n (%)**		**n (%)**		**n (%)**	
Single	31 (27)		28 (28)		59 (28)	
2–4	22 (19)		23 (23)		45 (21)	
5+	45 (39)		35 (35)		80 (38)	
Unknown	16 (14)		13 (13)		29 (14)	
Total	114		99		213	
Duration between onset and discovery of sexual abuse	**n (%)**		**n (%)**		**n (%)**	
Less than 6 months	59 (53)		51 (52)		110 (52)	
6–12 months	19 (17)		23 (23)		42 (20)	
More than 12 months	34 (30)		25 (25)		59 (28)	
Total	112		99		211	
Relationship of perpetrator with child	**n (%)**		**n (%)**		**n (%)**	
Intra-familial	60 (58)		64 (72)		124 (65)	
Extra-familial	43 (42)		25 (28)		68 (35)	
Total	103		89		192	
Number of perpetrators	**n (%)**		**n (%)**		**n (%)**	
Single perpetrator	97 (82)		81 (78)		178 (80)	
2+ perpetrators	13 (11)		10 (10)		23 (10)	
Unknown	9 (8)		13 (13)		22 (10)	
Total	119		104		223	

	Intervention	Waiting List	Total
Perpetrator gender	**n (%)**	**n (%)**	**n (%)**
Male	76 (96)	67 (91)	143 (93)
Female	2 (3)	5 (7)	7 (5)
Male and Female	1 (1)	2 (3)	3 (2)
Total	79	74	153
Perpetrator age (includes multiple abusers per child)	**n (%)**	**n (%)**	**n (%)**
Adult	69 (58)	59 (58)	128 (58)
Young Person over 14 years	23 (19)	25 (25)	48 (22)
Young Person 11–13 years	11 (9)	9 (9)	20 (9)
Children aged 10 and under	14 (12)	9 (9)	23 (11)
Unknown	6 (5)	1 (1)	7 (3)
Total	118	101	219

There were no statistically significant differences between groups except for the relationship of the perpetrator to the child. The proportion of children in the intervention group experiencing intra–familial abuse was significantly smaller than the waiting list group and the proportion experiencing extra-familial abuse was significantly larger (Chi-square = 3.894, p = 0.048).

Table 3: Children's experiences of sexual abuse by age group (TSCYC/ TSCC) (Case Descriptor Record)

	Younger children (TSCYC)		Older children and young people (TSCC)	
Mean age of child at onset of sexual abuse	**Mean (yrs)**	**SD**	**Mean (yrs)**	**SD**
	3.4	2.56	8	4.71
Age group of child at onset of sexual abuse	**n (%)**		**n (%)**	
Less than 3 years	19 (33)		25 (15)	
3–7 years	38 (67)		47 (28)	
8–12 years	–		59 (36)	
13+ years	–		35 (21)	
Total	57		166	
Nature of sexual abuse (includes multiple forms of abuse per child)	**n (%)**		**n (%)**	
Non-contact	6 (11)		21 (13)	
Online sexual abuse	1 (2)		8 (5)	
Inappropriate touching	42 (75)		101 (62)	
Penetration or attempted penetration	20 (36)		88 (54)	
Sexual abuse accompanied by gratuitous violence	2 (4)		10 (6)	
Total	56		162	
Number of known incidents of sexual abuse	**n (%)**		**n (%)**	
Single	13 (24)		46 (29)	
2–4	11 (20)		34 (21)	
5+	23 (43)		57 (36)	
Unknown	7 (13)		22 (14)	
Total	54		159	
Duration between onset and discovery of sexual abuse	**n (%)**		**n (%)**	
Less than 6 months	38 (72)		72 (46)	
6–12 months	8 (15)		34 (22)	
More than 12 months	7 (13)		52 (33)	
Total	53		158	
Relationship of perpetrator with child	**n (%)**		**n (%)**	
Intra-familial	35 (76)		89 (61)	
Extra-familial	11 (24)		57 (39)	
Total	46		146	
Number of perpetrators	**n (%)**		**n (%)**	
Single perpetrator	45 (79)		133 (80)	
2+ perpetrators	7 (12)		16 (10)	
Unknown	5 (9)		17 (10)	
Total	57		166	
Perpetrator gender	**n (%)**		**n (%)**	
Male	32 (91)		111 (94)	
Female	3 (9)		4 (3)	
Male and Female	0		3 (3)	
Total	35		118	

	Younger children (TSCYC)	Older children and young people (TSCC)
Perpetrator age (includes multiple abusers per child)	**n (%)**	**n (%)**
Adult	30 (56)	98 (59)
Young Person over 14 years	7 (13)	41 (25)
Young Person 11–13 years	5 (9)	15 (9)
Children aged 10 and under	14 (26)	9 (5)
Unknown	1 (2)	6 (4)
Total	54	165

2.2.3 Extent of polyvictimisation

Finkelhor and colleagues (2011) suggest that children who experience repeated victimisations and polyvictimisation may be at greater risk for experiencing complex trauma responses. Polyvictimisation is defined as having experienced multiple victimisations of different kinds in addition to sexual abuse, such as physical abuse, bullying, crime and exposure to family violence. Using data from a large US nationally representative NatSCEV sample of over 4,500 children, Finkelhor and colleagues (2011) found that polyvictimised young people not only had a disproportionate share of the most serious kinds of victimisations, including sexual abuse and parental maltreatment, they also had more life adversities and were more likely to have more pronounced symptoms of psychological distress, including PTSD, than non–polyvictims.

A version of Finkelhor et al's (2005) Juvenile Victimisation Questionnaire (JVQ) was used to measure the incidence of different forms of abuse in the child's life over the previous 12 months. This was adapted in consultation with Dr Finkelhor to ensure the language used was suitable for the UK population. The questionnaire was completed by children, although carers of younger children completed a proxy version – our guidance to teams was children aged seven years and younger but there was flexibility around this dependent on the practitioner's professional judgement of the child's capacity to self–report.

The older children and young people who had self–completed the TSCC (n=142) reported instances in addition to sexual abuse, as shown in Figure 2 below. These included being attacked with sticks, stones or knives (22% of children and young people), being attacked without an object (41%), being attacked by a gang (18%), receiving upsetting verbal abuse from an adult close to them in their lives (31%), being physically abused by a young person they know (51%), verbal bullying by children (58%), witnessing parental domestic violence (10%), and witnessing someone getting attacked without

an object (32%). Eight children (6%) had seen or heard someone being shot at or witnessed riots. Over half (53%) met the criterion for polyvictimisation, defined as three or more types of abuse, in addition to sexual abuse.

In addition, carers of 67 younger children completed a proxy version of the measure. According to the carers, the incidence of victimisation among younger children was reportedly much lower than for the older children and young people who self-reported. This indicated that the most common form of victimisation among younger people was physical abuse without an object (28%) and verbal abuse by other children (29%) and by adults known to them (125). Overall, one third of younger children met the criterion for polyvictimisation (see Figure 3 below).

There were no statistically significant differences in polyvictimisation rates between children in the intervention and the waiting list control groups for either age grouping.

Figure 2: Instances of victimisation reported by older children and young people (TSCC group) at baseline (T1) (N =142: Intervention=75, Waiting list=67)
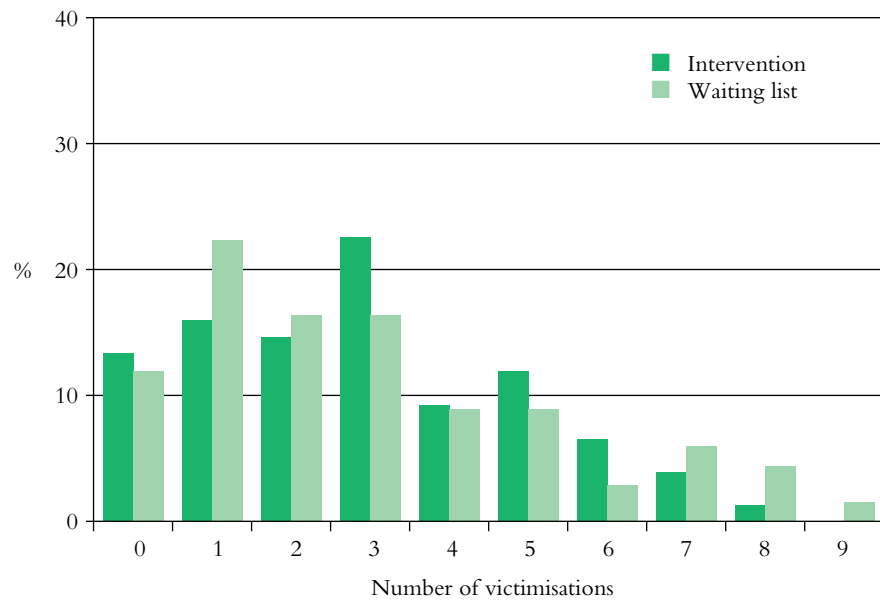
Figure 3: Instances of victimisation of young children at baseline (T1)
(N = 52: Immediate=32, Waiting list=20) reported by carers.
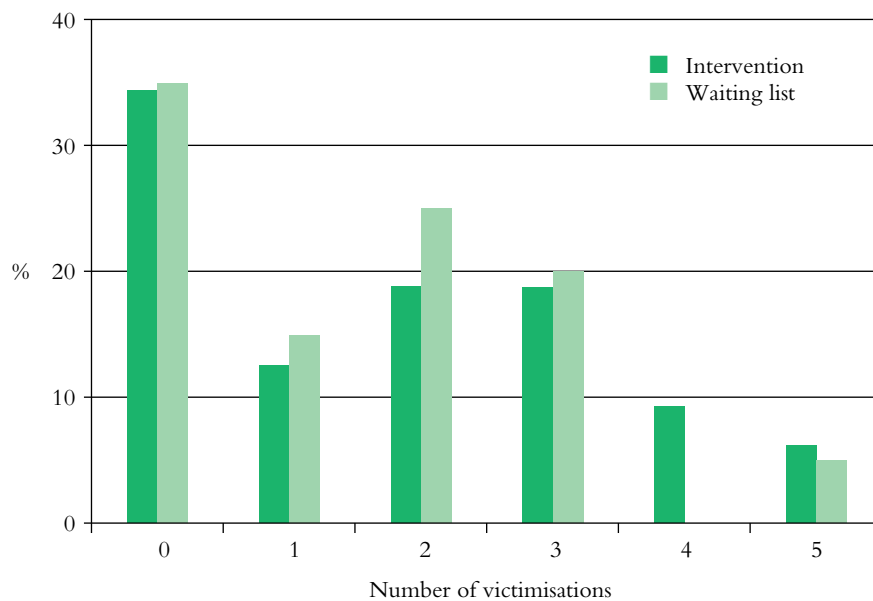
2.2.4 Proportion of children with 'clinical' and 'significant' difficulty' scores at baseline

The most common frequently studied outcomes of therapeutic interventions are internalising symptoms (such as anxiety and depression), externalising behaviour (such as anger and aggression), sexualised behaviour (such as age-inappropriate sexualised behaviour) and post-traumatic stress (Harvey & Taylor, 2010). These outcomes were measured using the Trauma Symptoms Checklist for Children (TSCC) (Briere, 1996).

The NSPCC teams implementing LTFI were already using the TSCC, which is a valid and reliable measure that has been standardised in the US with diverse samples. Its six subscales have demonstrated high internal consistency, and psychometric evaluations have shown strong construct validity, convergent and discriminant validity and criterion validity (Strand et al, 2005). The scale is validated for children and young people aged eight to 16.

In the case of children aged seven and under, the Trauma Symptom Checklist for Young Children (TSCYC) (Briere et al, 2001) was being used. This measure is completed by the safe carer and comprises seven discrete scales measuring similar domains as the TSCC. Although used for quite young children, its reliability appears to have been established in a study where the mean age was 7.1 years (Strand et al, 2005). Otherwise, it has good construct validity (less so for the internalising scales, which is not surprising) and good predictive ability.

For children between eight and 12 years of age, both the age *and* cognitive ability of the child or young person determined the appropriate primary outcome measure used in the study. Practitioners administering the measures used their professional judgement as to whether the TSCC (self-report) or TSCYC (carer report) would be more helpful and appropriate. Therefore, although the majority of the 80 children for whom the TSCYC was used were under eight years of age, 20 were over eight (8 were eight years old, 7 were nine years, 3 were ten and 1 child was eleven years old). Throughout the remainder of this report we use the terms 'young children' to describe the TSCYC group and 'older children and young people' to describe the TSCC group. Readers should be aware that 'older children' may still be as young as eight years old.

Over half (57%) of children had a 'clinical' level score on at least one of the TSCC subscales and the proportion rose to 70% when children with one or more 'significant difficulties' were included. As shown in Figure 4 below, half had clinical or difficulty level ratings on post–traumatic stress at this time and four in ten for anxiety and depression. Over a third showed evidence of dissociation (defined as a conscious or unconscious disruption in a person's awareness, feelings, thoughts, behaviour and memories in order to reduce psychological distress) and sexual distress, and a quarter had significant scores for anger and sexual concerns. There were no statistically significant differences between the intervention and control groups on these subscale scores at baseline.

Figure 4: Proportion of older children and young people with clinical/difficulty scores on TSCC subscales at T1 Intervention (IG, N=82) and Waiting list (WL, N=79) groups (N =161)[5]
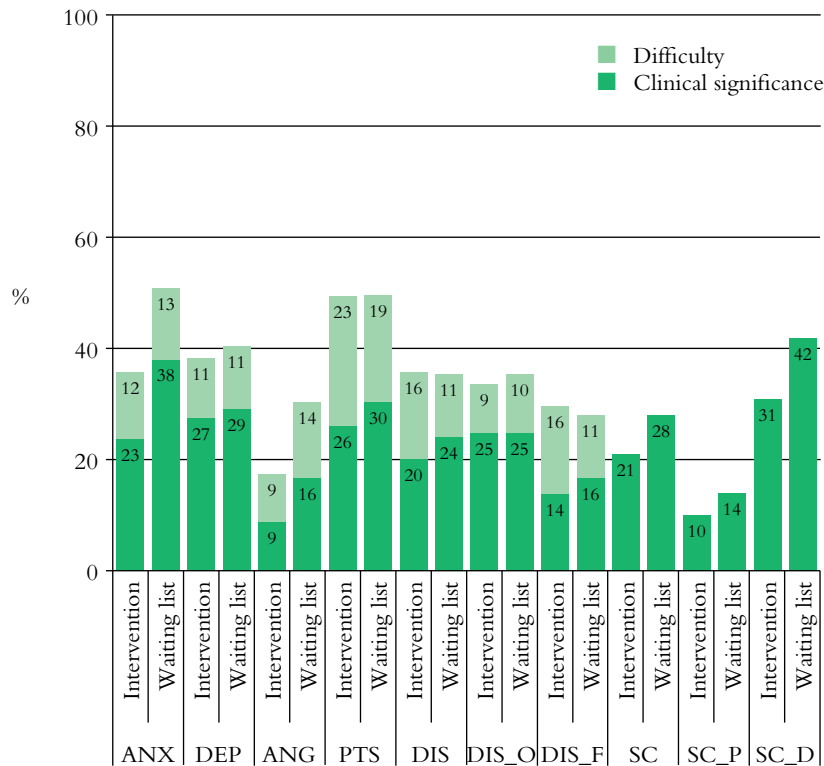
The young children were rated on the TSCYC by their carer and as Figure 5 below illustrates, a high proportion of these children (86%) were given one or more clinical level subscale ratings and this reached 93% when those with significant difficulties were added. Considering the subscale scores, over half had clinical/difficulty combined scores for anxiety, depression and anger. Almost three quarters showed evidence of post-traumatic stress (64% clinically) and nearly half of dissociation. Nearly half the carers indicated significant difficulty or clinical levels of sexual concerns.

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5 One child missing at T1. TSCYC was completed instead, but at T2 and T3, the TSCC was completed.

Note that these ratings were much higher than the proportions reported by the older children and young people using the TSCC. It might be suggested that the older children were under-reporting their problems and symptoms and the carers over-reporting their children's. The only paper to report on the relationship between these two scales (Lanktree et al, 2008)[6] concluded that: "The TSCC and TSCYC display moderate convergent and discriminant validity with respect to one another, despite different information sources. Nevertheless, the relatively small association between relevant TSCC and TSCYC scales indicates that different symptom informants may have different perspectives on the child's symptomatology." In that study, participants in two child abuse treatment centres in the USA were assessed as part of a standard intake procedure.

Figure 5: Proportion of young children with clinical/difficulty scores on TSCYC subscales at T1 Intervention (IG, N=46) and Waiting List (WL, N=34)
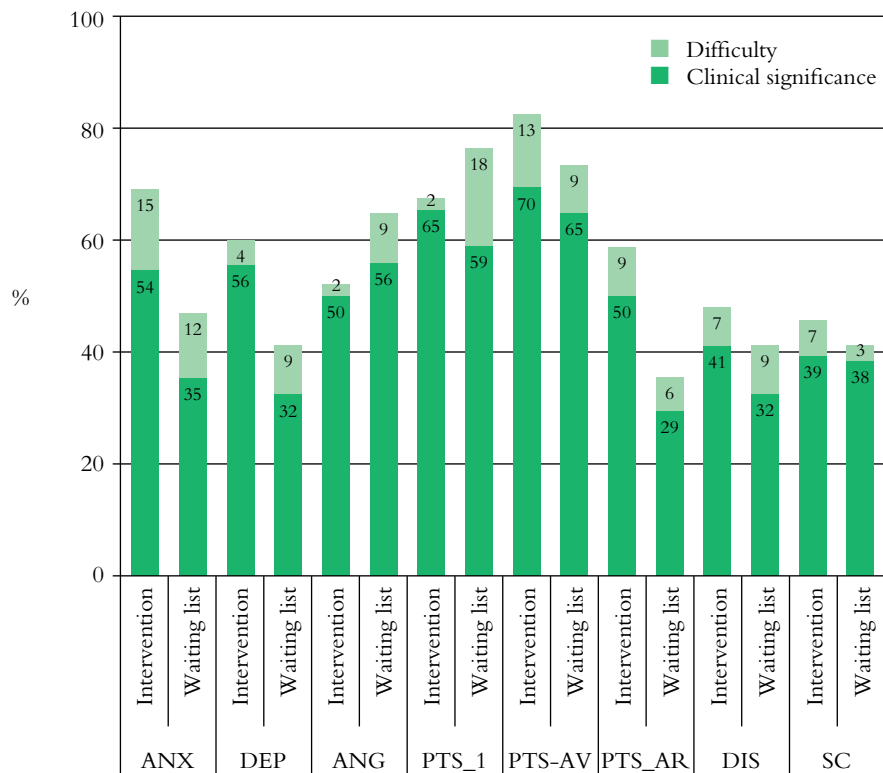
6   Lanktree C. et al (2008) Multi-informant assessment of maltreated children: Convergent and discriminant validity of the TSCC and TSCYC, *Child Abuse and Neglect*, 32, 621–625.

2.2.5 Predictors of baseline TSCC and TSCYC scores

We carried out a series of regression analyses, seeking to identify the statistical predictors of there being one or more measures reaching clinical significance at baseline TSCC and TSCYC total scores. The predictor variables were age group, gender, disability, ethnic group (white or BME), the relationship of the child to the perpetrator (intra- or extra-familial), the nature of abuse (penetration or attempted penetration), and polyvictimisation. However, the statistical models were weak and statistically significant solely for the TSCC, with only gender (being female) and polyvictimisation being statistically significant variables. Nevertheless, we included gender, nature of abuse and the relationship of the child to the perpetrator along with baseline scores as variables in the multiple imputation of missing data employed for the intention to treat analysis described below.

2.3 Carers

2.3.1 Description of sample

Carer participation was not a requirement of the intervention or the evaluation, but a high proportion (91%) elected to take part in the latter. Carers who had agreed to participate in the evaluation but who did not engage in the intervention were nevertheless asked to complete the outcome measures at T2 and T3.

The demographics of the 165 safe carers in the RCT for which we have data are shown in Table 4 below. The overwhelming majority (89%) of safe carers were female, and 63% were aged 30–49. Carers from Black or other minority ethnic backgrounds were few (4%), although ethnicity was unknown in 11% of cases. The most frequent relationship of safe carers to children in the RCT was mother (70%), with fathers acting as the primary safe carer engaged in LTFI in a further 9% of cases. Other types of relationship included foster carers (6%), and grandmothers (5%). There were a small number of cases in which an adoptive- or stepmother, aunt, or other family member acted as the primary safe carer.

Table 4: Background demographics and relationship of primary carers by RCT group (N=165).

	Intervention n=89	Waiting List n=76	Total n=165
	n (%)	n (%)	n (%)
Gender			
Female	77 (87)	69 (91)	146 (89)
Male	8 (9)	5 (7)	13 (8)
Unknown	4 (5)	2 (3)	6 (4)
Age Group (years)			
20–29	9 (10)	10 (13)	19 (12)
30–39	28 (32)	31 (41)	59 (36)
40–49	28 (32)	16 (21)	44 (27)
50+	9 (10)	5 (7)	14 (9)
Unknown	15 (17)	14 (18)	29 (18)
Ethnicity			
White	77 (87)	63 (83)	140 (85)
Black and Minority Ethnicity	3 (3)	4 (5)	7 (4)
Unknown	9 (10)	9 (12)	18 (11)
Relationship to child/young person			
Mother	63 (71)	52 (68)	115 (70)
Father	9 (10)	5 (7)	14 (9)
Adoptive mother	0	3 (4)	2 (2)
Stepmother	0	4 (5)	4 (2)
Aunt	2 (2)	0	2 (1)
Foster carer	5 (6)	4 (5)	9 (6)
Grandmother	5 (6)	3 (4)	8 (5)
Other family member	2 (2)	2 (3)	4 (2)
Unknown	3 (3)	2 (3)	5 (3)

Note: There were no statistically significant differences between Intervention and Waiting list groups in terms of carer demographics. Information on role/relationship of carers to children and young people was derived using person number matches available in the NSPCC's database.

The flow of carer participants in the trial is shown in Figure 6 below. The cases that declined to consent to the trial or were removed from the waiting list group are the same as those outlined in the CONSORT for children in the trial (see Figure 1 previously). In addition, nine carers declined consent to complete the outcome measure, and in four cases there was no appropriate carer because the child was in residential care or only very recently placed in foster care. In five cases, practitioners forgot to administer the carer measure at T1.

Again, by T2 there was some attrition, and this time more so in the intervention group. The majority of 'lost' cases were attributed to the child disengaging from LTFI (in both intervention and control groups), and, in addition, 12 more carers declined consent at this stage. However, eight carers who had declined consent at baseline did agree to complete the outcome measure after six months. Attrition at T3 was in most part due to teams overlooking data collection at 12 months. Full details are in Figure 6 below.

2.3.2 Defining outcomes for carers

The outcomes for carers was a secondary outcome of the RCT. From a family systems perspective, we expected that the child's intervention would affect the safe carer, whether or not the carer received a direct intervention her/himself. Conversely, if the carer received the carers' support intervention, we would expect a stronger impact.

To assess possible changes, the safe carers were asked to complete the Parenting Stress Index (Short Version) (PSI–SF) (Abidin, 1995). The PSI was developed on the theory that the total stress a parent experiences is a function of certain salient child characteristics, parent characteristics, and situations that are directly related to the role of being a parent. The PSI–SF consists of 36 items comprising three scales: Parental Distress; Difficult Child Characteristics; and Dysfunctional Parent–Child Interaction. The PSI–SF yields a Total Stress score from the three scales. In addition, there is a "Defensive Responding" scale designed to assess the possible invalidity of responses.

Figure 6: CONSORT flowchart of carers in the RCT

Child and carer assessed for eligibility (n=297)

Child excluded, not met inclusion criteria (n=14)

Randomised (n=281)

Allocation (T1)

Immediate Intervention (n=140)

Waiting list (n=141)

Declined to consent to evaluation (n=14)

Declined to consent to evaluation (n=12)

Child removed from W/L and Protocol errors (n=13)

(See Child CONSORT chart for details)

PSI T1 data completed (n=120)

Team protocol error (n=2)

Child in residential care, not appropriate (n=2)

Carer declined consent to complete PSI at T1 (n=4)

PSI T1 data completed (n=104)

Team protocol error (n=3)

No appropriate carer (n=2)

Carer declined consent to complete PSI at T1 (n=5)

Intervention

Waiting List

Follow-up (T2)

Lost to follow-up (n=45) **Discontinued intervention before T2 (n=26)** See Child CONSORT chart for details. **Protocol error (team overlooked T2 data) (n=1)** **Case closed by team:** Following therapeutic assessment, service not needed and not followed up **(n=2)** Referred to another service **(n=5)** No appropriate carer at T2 **(n=2)** Carer did not consent for PSI at T2 **(n=9)**	**Lost to follow-up (n=34)** **Removed from Waiting List (**Cases in crisis and removed according to protocol **(n=6)** **Did not return to service after W/L period and no data collected (n=24)** Family moved out of area (n=2) Family declined service (n=14) NSPCC decision not to offer service (n=5) No contact achieved (n=3) No appropriate carer at T2 **(n=1)** Carer refused consent for PSI at T2 **(n-3)** **Team protocol error (n=1)**
Data collected at T2 (but not at T1) (n=3)	**Data collected at T2 (but not at T1) (n=5)**

Analysis (T2)

T2 data completed (n=78) T1/T2 data available 78/120 (65%)	**T2 data completed (n=75)** T1/T2 data available 75/104 (72%)

Follow-up (T3)

Lost to follow-up (n=46) Child disengaged and declined further consent **(n=5)** Child disengaged and clinical decision not to re-contact **(n=4)** Family moved out of area **(n=2)** No contact achieved **(n=9)** Protocol error (team overlooked T3 data**) (n=26)**	**Lost to follow-up (n=40)** Child disengaged and declined further consent **(n=8)** Child disengaged and clinical decision not to re-contact **(n=2)** No contact achieved **(n=3)** Protocol error (team overlooked T3 data**) (n=27)**
Data collected at T3 (but not at T2) (n=5)	

Analysis (T3)

T3 data completed (n=37)	**T3 data completed (n=35)**

3. The intervention

We designed an Intervention Checklist (ICL) to record the number of sessions, the participants and the interventions used. The ICL was developed to reflect the interventions recommended in the practice guide, such as socio-educative work, play and CBT techniques. It was reviewed by a panel of NSPCC practitioners and the development manager, and in its final form covered 15 specific interventions. Once the therapeutic assessment sessions had been completed, practitioners were asked to record the main and secondary interventions that they used in each session with the child or safe carer. Practitioners also recorded whether the session was an individual session with the child or the safe carer, or a joint session with both child and safe carer(s) present.

Tables 5 and 6 below show the number and types of session for the older children and young people and for the younger children respectively. Data was available concerning the interventions received for 157 children and young people. This comprised 92 out of 128 of those who received immediate intervention (the intervention group, some of whom discontinued the intervention before T2) and 65 of the 79 children on the waiting list group who returned to receive their intervention after the six-month wait. The waiting list group is included in the analysis, both because this gives a fuller picture of the types of intervention used and also because we report the outcomes of their intervention below. There were few differences between the two age groups in the mean total number of sessions received, but overall, the younger children had twice as many joint sessions as the older group.

Table 5: TSCC group: Number and type of intervention sessions by intervention and waiting list group

Session type	Intervention				Waiting list				Total			
	n	Mn	SD	Median	n	Mn	SD	Median	n	Mn	SD	Median
All sessions	56	20.0	10.38	19.5	46	16.5	9.19	17.0	102	18.4	9.96	17.0
Individual work with child	56	15.6	8.68	15.0	46	13.4	8.39	11.5	102	14.6	8.58	14.0
Safe carer work	56	2.7	3.57	0	46	2.2	3.34	0	102	2.5	3.46	0
Safe carer and child joint work	56	1.8	2.94	1.0	46	1.0	1.65	0	102	1.4	2.46	0

Table 6: TSCYC group: Number and type of intervention sessions by intervention and waiting list control group

Session type	Intervention				Waiting list				Total			
	n	Mn	SD	Median	n	Mn	SD	Median	n	Mn	SD	Median
All	36	20.5	13.09	17.5	19	17.7	10.67	15.0	55	19.6	12.28	17.0
Individual work with child	36	14.5	8.01	14.5	19	10.9	8.79	7.0	55	13.2	8.38	12.0
Safe carer work	36	4.3	7.28	0	19	1.6	2.59	0	55	3.4	6.19	0
Safe carer and child joint work	36	1.8	3.94	0.5	19	5.3	10.57	0	55	3.0	7.09	0

3.1 Number of individual intervention sessions with children

The distribution of individual intervention sessions for all 157 cases is shown in Figure 7 below. Children received between none and 36 individual sessions. Ten children had no individual intervention sessions, although they did have joint sessions with a carer present. A small proportion of children (around 11%) received more than the guide's recommendation of an initial 20 intervention sessions. The average number of individual sessions received by the combined intervention and the waiting list group (once their therapeutic work began) was 14.12.

Figure 7: Number of individual intervention sessions received (all children and young people N =157)
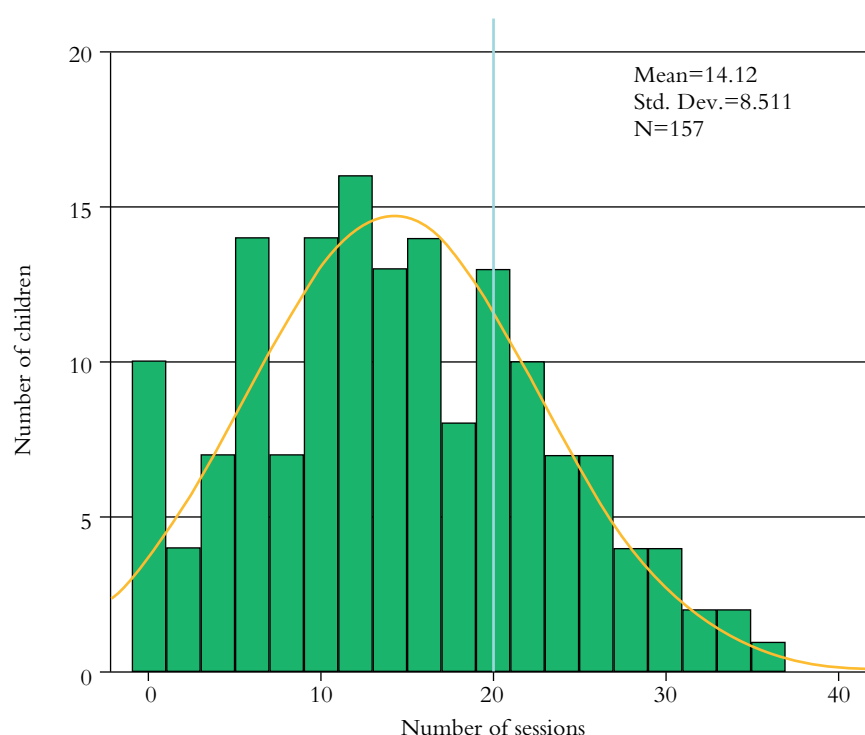
Note: Vertical blue line indicates 20 sessions

Examination of the Intervention Checklist dates showed that many individual sessions took place after the T2 (six-month) assessment, for both the older children and young people, and younger children's groups. Table 7 presents the mean number of sessions that the TSCC and TSCYC intervention groups received between T1 and T2, and T2 and T3 respectively. The data is further broken down to show the Analysis Completers at all three time points and those who completed at T1 and T2, but dropped out at T3.

Thus, for the TSCC group, the T1, T2, and T3 Analysis Completers received a mean of 10.1 sessions between T1 and T2, and a further mean 6.3 sessions between T2 and T3. The group who subsequently dropped out after T2 received a mean of 8.3 sessions in the first period and 3.8 in the second.

The younger children (TSCYC group) received only seven sessions on average between T1 and T2, but the Analysis Completers went on to receive an additional 9.5 sessions by T3. Those who dropped out before T3 received an additional 4.6 sessions.

Table 7: Intervention group: Individual intervention sessions with child by time period and completers' grouping, TSCC and TSCYC age groups. Number of children and mean number of sessions

| Group | Analysis | Individual work with child | | | | | | | | | | | |
| | | All sessions | | | | T1–T2 | | | | T2–T3 | | | |
		N	Mn	SD	Sum	N	Mn	SD	Sum	N	Mn	SD	Sum
TSCC	Completer (T1,T2,T3)	32	18.7	8.33	597	32	10.1	4.49	322	32	6.3	4.66	203
	Drop-out (T2–T3)	19	12.8	7.87	243	19	8.3	5.00	157	19	3.8	3.32	73
	Drop-out (T1–T2)	5	6.8	3.19	34	5	5.2	2.28	26	5	1.4	1.52	7
Total		102	14.6	8.58	1489	102	5.0	5.63	515	102	6.2	4.69	630
TSCYC	Completer (T1.T2,T3)	15	19.2	8.20	288	15	7.1	5.04	107	15	9.5	4.84	143
	Drop-out (T2–T3)	17	12.2	4.93	208	17	7.0	4.34	119	17	4.6	3.35	79
	Drop-out (T1–T2)	4	6.3	8.66	25	4	4.5	7.05	18	4	1.5	1.91	6
Total		55	13.2	8.38	728	55	4.5	5.08	245	55	6.3	5.00	348

3.1.1 Joint sessions with children and carers

In just under half the cases for which we have data (n=74, 47%), joint sessions with a safe carer were recorded (see Figure 8 below). The reasons why over half did not engage in these sessions was not recorded. For cases with one or more joint sessions, the median was two sessions (mean = 4.2, SD = 6.01), but as can be seen below in Figure 8, the distribution was skewed, with a few cases receiving eight or more. The mean number of joint sessions for children and carers was 1.98, with few (14%) cases receiving four or more such sessions.

Figure 8: Number of safe carer sessions (N=157)
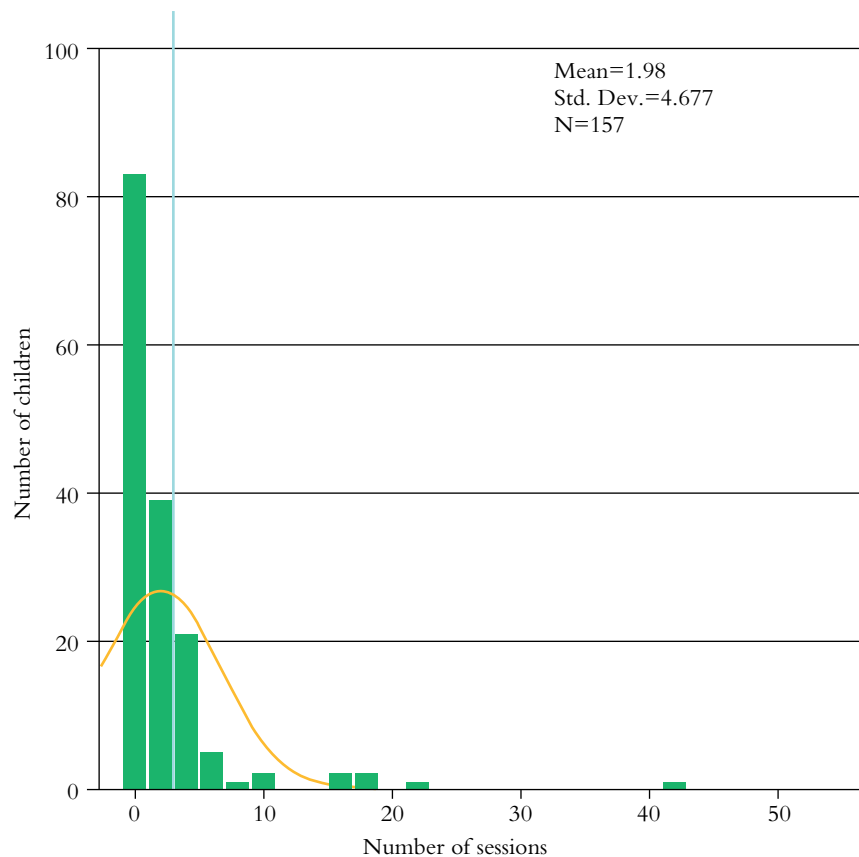
Note: Vertical blue line indicates three sessions

3.2 Analysis of content of the sessions with children and young people

Table 8 shows the number of times each of the 15 specific interventions were recorded as the primary intervention within an individual session with a child. Data is shown for 2,713 individual sessions with children in the RCT. The intervention most frequently recorded as the primary intervention (in 20% of all individual sessions with children and young people) was creative therapies, followed by awareness and management of feelings (17%). Cognitive Behavioural Therapy (CBT) was recorded as the main primary intervention in less than four per cent of sessions.

Table 8: Primary intervention recorded for individual intervention
sessions with all children and young people (N=147)

Intervention type	Primary Intervention n=2,713
	n (%)
Using scales and tools	108 (4)
Agreement and boundary formation	136 (5)
Attachment based	81 (3)
Socio–educative	247 (9)
Identity and self–esteem	248 (9)
Awareness and management of feelings	461 (17)
Sexually inappropriate behaviours	12 (0)
General CBT	77 (3)
Trauma–focused CBT	17 (1)
Creative therapies	546 (20)
Symbolic play	221 (8)
Counselling	408 (15)
Solution–focused brief therapy	124 (5)
Motivational interviewing	8 (0)
Gradual exposure	19 (1)

The relative proportion of interventions used across the different age
groups of children varied, as shown in Figure 9 below. In relation
to older children (the TSCC group), the four most commonly
reported primary interventions were: creative therapies; awareness
and management of feelings; counselling; and identity and self-esteem
work. Taken together, these four types of intervention account for
67% of all reported primary interventions used with older children (as
in Figure 9).

As it could have been the case that other types of intervention were
frequently used but not identified as the primary intervention in
a session, practitioners were also asked to indicate the secondary
intervention types offered in sessions (not depicted). The four most
commonly cited primary interventions for older children were also the
most frequently used secondary interventions, accounting for 75% of
all those offered with older children. As might be expected given their
developmental status, in sessions for older children and young people,
practitioners rarely reported the use of symbolic play.

By contrast, in relation to younger children (the TSCYC group),
the three most commonly reported interventions were: creative
therapies; symbolic play; and awareness and management of feelings.
Together, these three interventions accounted for 69% of the primary
interventions and 62% of the secondary interventions cited with
younger children.

Figure 9 below also shows that the proportion of sessions using socio-educative work, agreement and boundary formation, and scales and tools did not differ much between the two age groups. The use of CBT was marginally greater among older children and young people, though the use of CBT, both general CBT and more specific trauma-focused CBT, was surprisingly low among all groups, representing only 4% of the primary interventions claimed by practitioners. This was also true for 'gradual exposure', which is a technique particularly associated with CBT, as well as motivational interviewing and solution-focused brief therapy.

CBT as a specific intervention is not emphasised as part of Bannister's (2003) model, although the LTFI guide goes some way to emphasising CBT as one of the range of interventions that might be warranted as part of the intervention, especially with older children.

Figure 9: Primary interventions used in individual therapy sessions with older children and young people (TSCC age group) and younger children (TSCYC age group) (N=147)
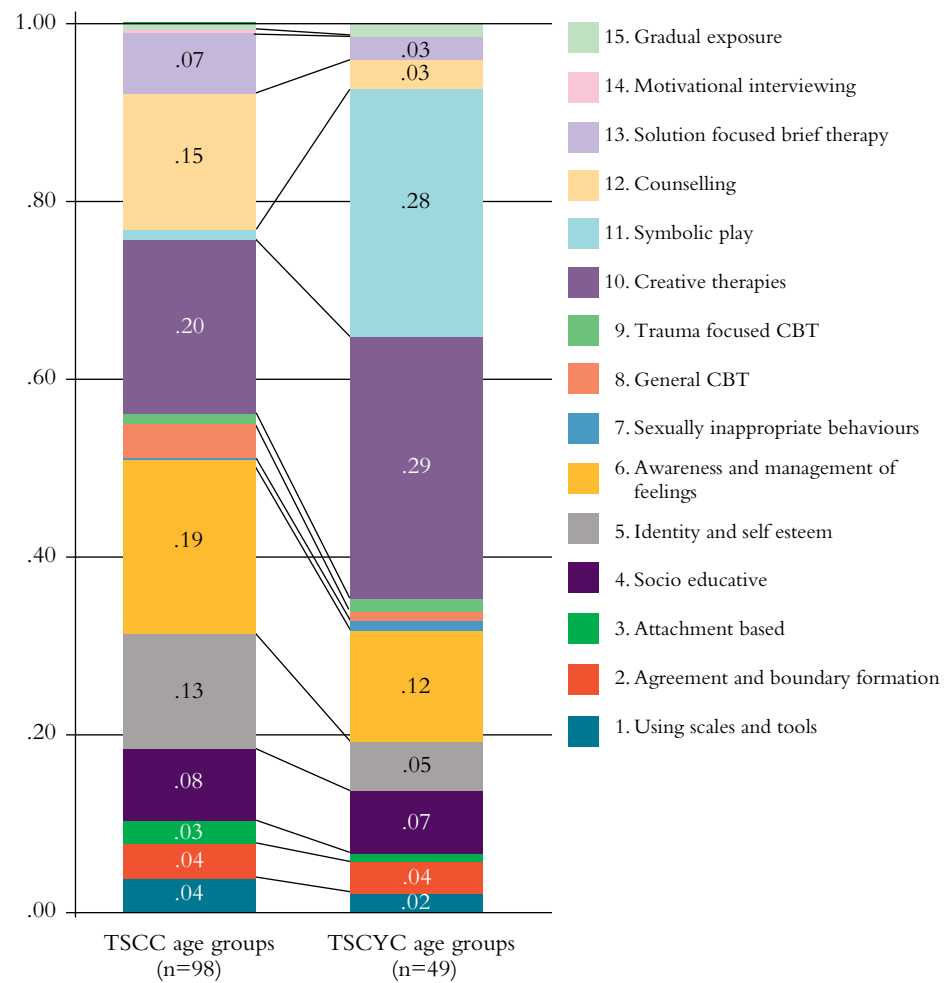

Differences were evident in the primary intervention used with children who experienced different types of sexual abuse. Figure 10 below shows the proportions for the five categories of sexual abuse.

The numbers of children experiencing non-contact, online sexual abuse and/or sexual abuse accompanied by gratuitous violence were low, making comparisons across groups less reliable. The use of counselling as the primary intervention was the highest proportion for the small group of children who had experienced abuse with gratuitous violence (n=7) and for non-contact abuse. The latter group received the highest proportion of socio-education about abuse.

The small group of children who were abused online (n=6) received a lot of work on awareness and management of feelings and identity and self-esteem. Creative therapies were used with all kinds of abuse but most commonly with children who experienced inappropriate touching or penetration (or attempted penetration) and infrequently in cases of sexual abuse and violence. Awareness and management of feelings were also commonly used with all types of abuse, particularly online abuse. Full details can be seen in Figure 10.
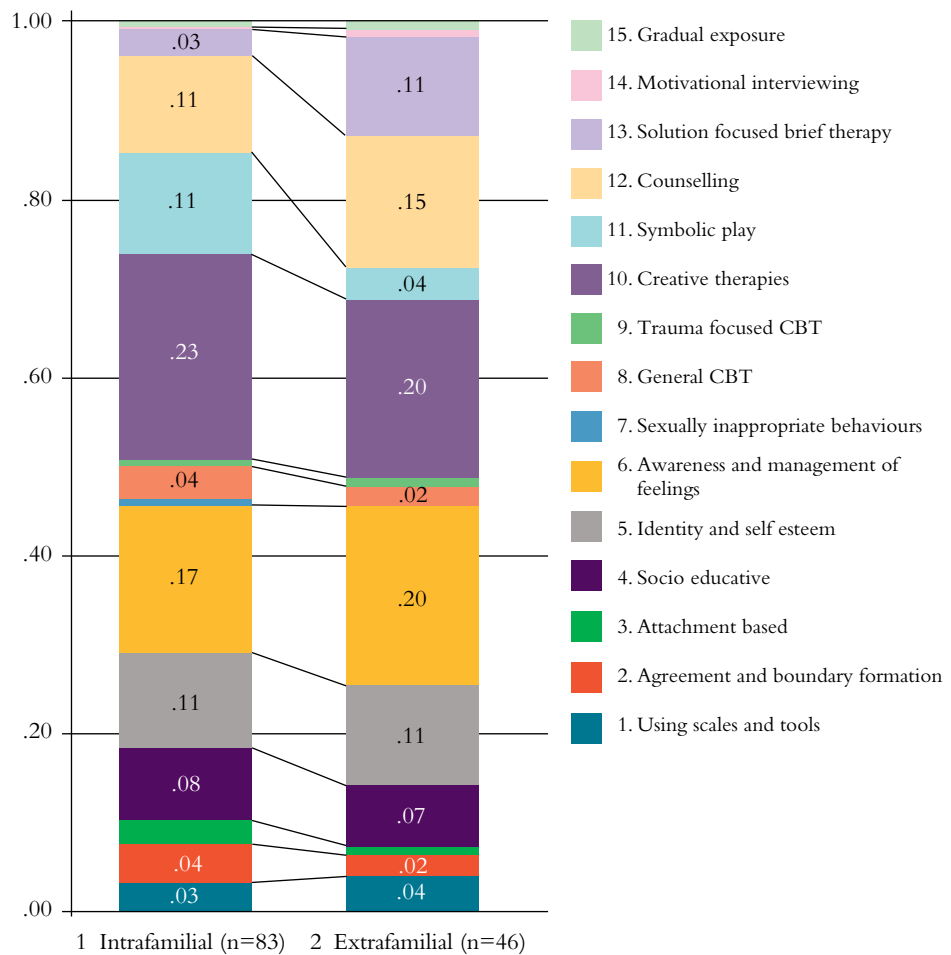
Figure 10: Primary interventions used in individual child sessions by type of sexual abuse (N=198) – more than one type of abuse could be recorded
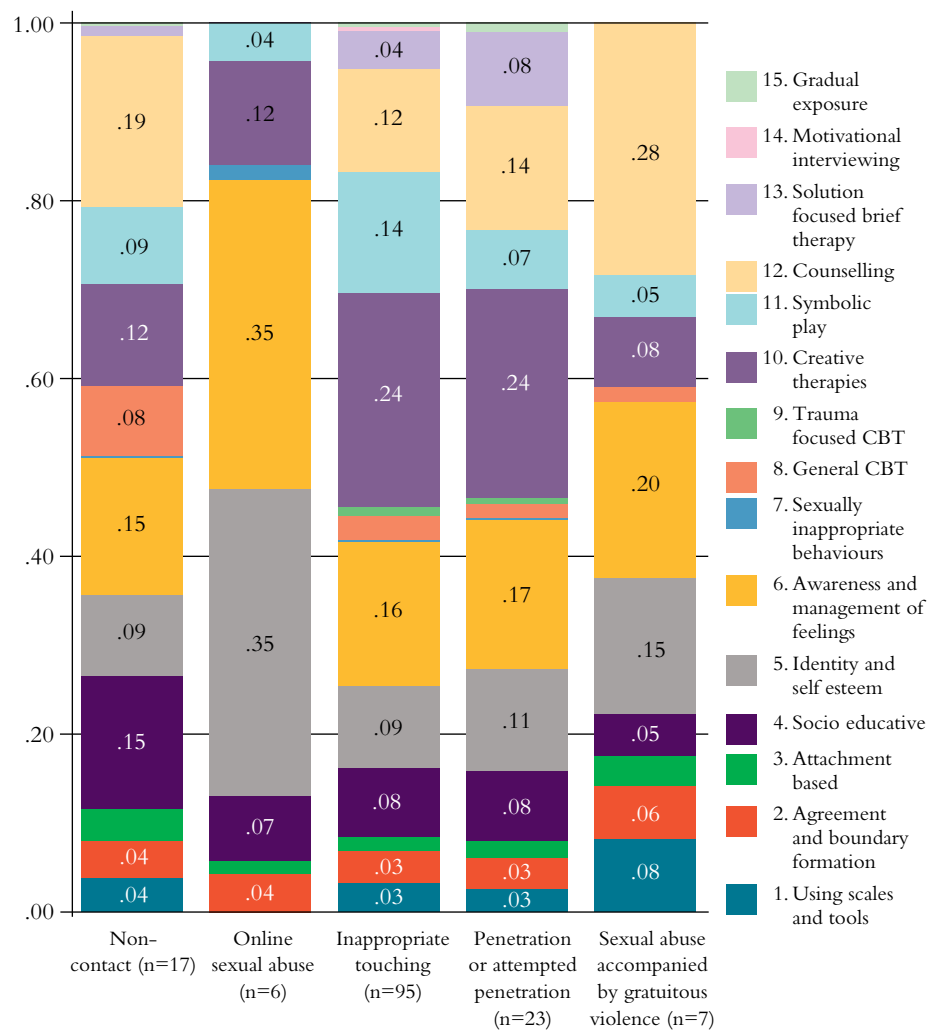
Finally, in relation to the interventions offered to children and young people, Figure 11 below shows the relationship between the primary

intervention and whether the child was abused by someone inside or outside of their family. Intra-familial victims were engaged in more symbolic play, whereas those abused outside the family were more likely to be offered solution-focused interventions. However, this difference is likely to be attributable to age differences between the groups, as those abused outside of the family were significantly more likely to be in the older age range, as shown in Table 3 previously. However, overall, the pattern of primary interventions (and indeed secondary interventions, not depicted here) varied remarkably little between these two abuse types, suggesting that practitioners did not differentiate in their choice of interventions offered to children who had been abused by people within and outside of their families.

Figure 11: Primary interventions used in individual child sessions by relationship with perpetrator (N=129)

3.3   Joint sessions with carers

Figure 12 below shows the proportions of the primary interventions used in joint sessions with carers and children. Over half the interventions were attachment-based work and awareness and

management of feelings, with some use of creative therapies. With the older children and young people, the same methods were used, along with scales and tools and socio-educative work in quite similar proportions.

Figure 12: Primary interventions used in joint sessions with carers and older children and young people (TSCC age group) and younger children (TSCYC age group) (N =73)

3.4 Joint sessions with carers

Figure 12 below shows the proportions of the primary interventions used in joint sessions with carers and children. Over half the interventions were attachment-based work and awareness and management of feelings, with some use of creative therapies. With the older children and young people, the same methods were used, along with scales and tools and socio-educative work in quite similar proportions.

Figure 12: Primary interventions used in joint sessions with carers and older children and young people (TSCC age group) and younger children (TSCYC age group) (N =73)
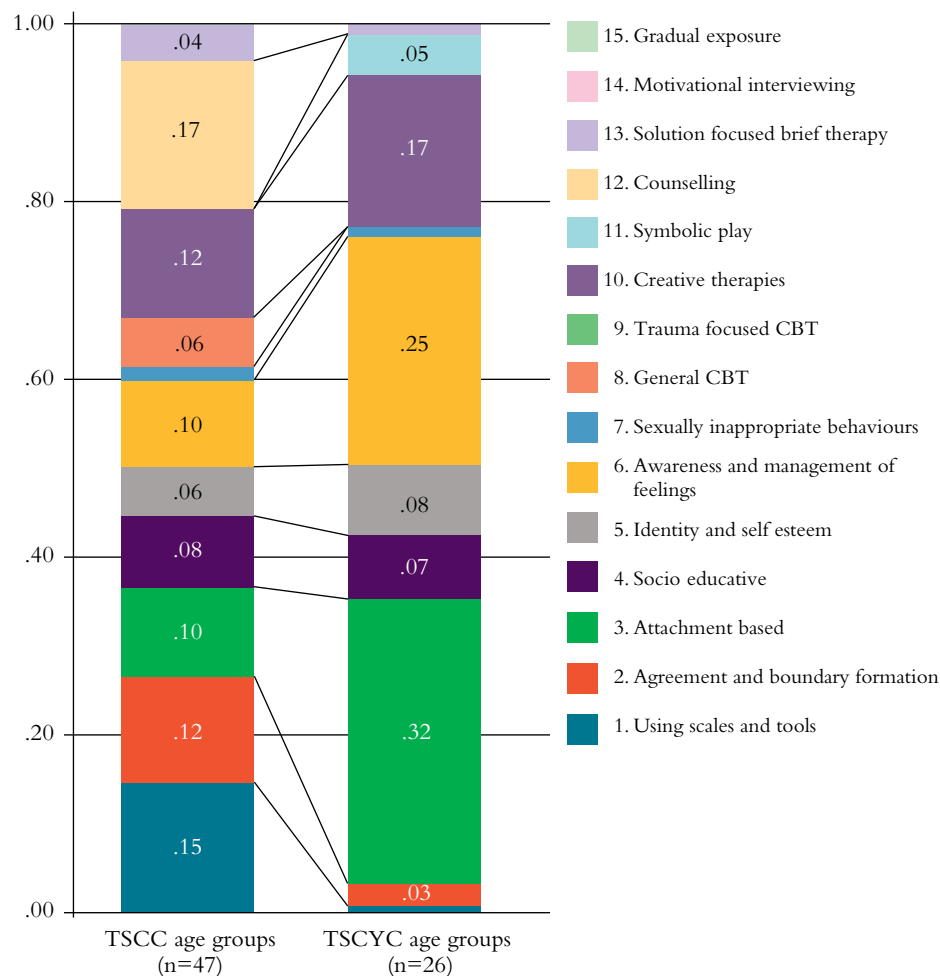
3.5 Number of individual sessions with carers

Of the 157 cases in the RCT for which we have data, only 63 (40%) had one or more individual sessions with a safe carer recorded. For those cases, the median number of sessions was six (range one to 29) with a mean of 6.9 (SD 4.92).

3.6 Contents of sessions with carers

Work with carers was generally based on counselling and the awareness and management of feelings, together with socio-educative work. If the abused child was in the younger group, there was a greater focus in the sessions on socio-educative work and agreement and boundary formation; by comparison, for older children, the proportions of counselling and work on the management of feelings was rather higher (see Figure 13 below).

Figure 13: Primary interventions in individual work with safe carers (N=56)
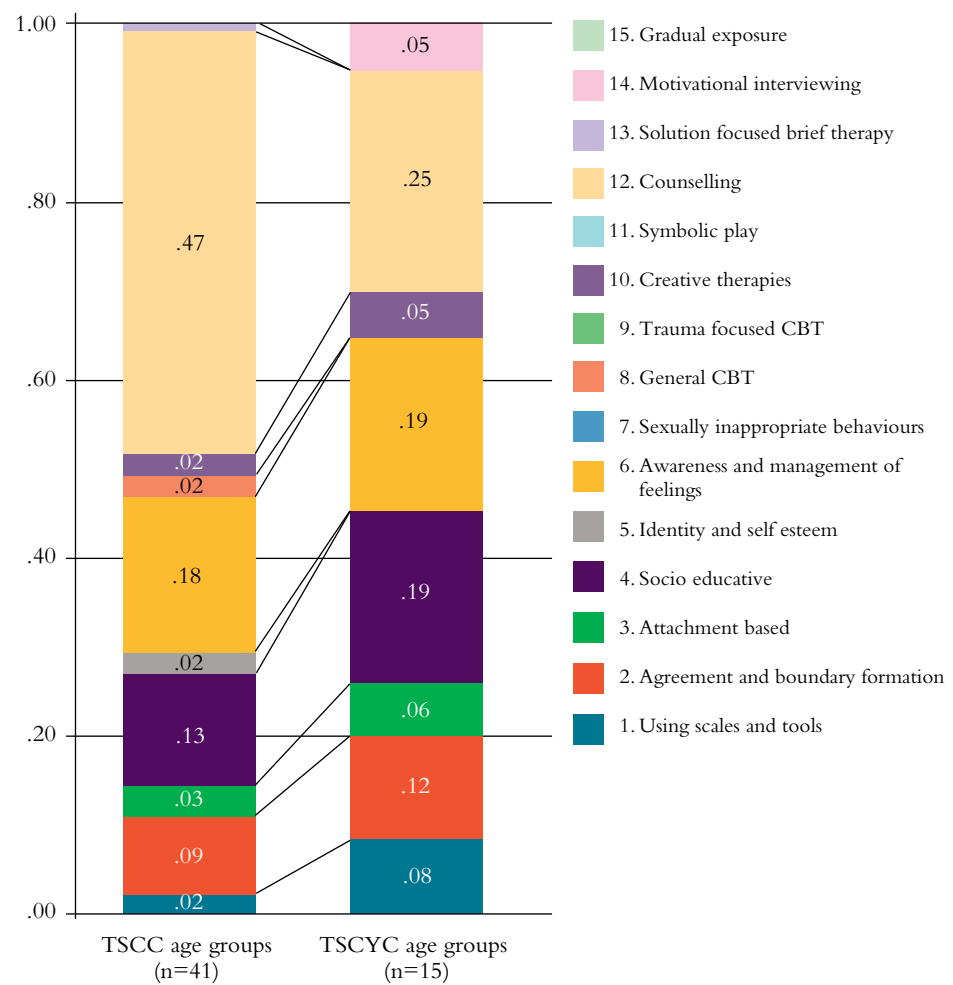
3.7 Therapeutic alliance

As explained previously in Section 1.5, the core theoretical model of the LTFI approach to working with children affected by sexual abuse is a revised version of Bannister's (2003) Recovery and Regeneration model, which is largely psychodynamic in nature and emphasises the therapeutic attunement of the worker to the child's affective states. Bannister explained that "the core of the regenerative model is, of course, the quality of the attachment with the therapist and the creativity of the action which takes place in the sessions." (p.138). From an evaluation perspective, elements of the working relationship or therapeutic alliance can act as:

1) moderators of the intervention effect in so far as they reflect *stable pre-intervention child or worker factors* that are independent of the intervention methods;

2) non-specific predictors of outcome unaffected by intervention (for example *stable during the intervention*) but have an interactive or main effect on the outcome;

3) mediators of the intervention in so far as they *change during the course of the intervention* and have an interactive or main effect on the outcome.

Bannister considered sexual abuse as a form of betrayal. She wrote: "One of the effects of betrayal is inability to trust, and since trust is at the heart of the therapeutic relationship this feeling can inhibit even the start of useful work" (Bannister, 1998, p.11). The assumption behind Bannister's model is that trust has to be built, that the strength of the therapeutic alliance will increase and that this will have a positive effect on the outcome for children. In other words, the therapeutic alliance will be a mediator of treatment outcome. In order to test this hypothesis, self-report measures were used to assess the children's and workers' perspectives of the therapeutic alliance.

The Therapeutic Alliance Scale for Children (TASC) (Shirk & Saiz, 1992) was administered to children and young people after the third intervention session (note that T1 for the TASC is later than the T1 baseline for measures used on referral) and again at T2, the six-month follow up time for all measures. There are two complementary versions, one completed by the practitioner and the other by the child; both comprise 12 items. Our guidance to teams was that children aged seven years and older should be asked to complete the scale but there

was flexibility around this dependent on the practitioner's professional judgement of the child's capacity to self-report. Children's completed scales were placed in an envelope and sent directly to the research team (and not shared with the practitioner).

A matched group of 55 older children and young people in the intervention group and the practitioners who worked with them completed the TASC at T1 and 40 at T2. At T1, the item mean total score of 3.61 out of 4 indicates that in general the children were very positive about their relationship with their worker.

Figure 14 below shows that the practitioners' responses were generally lower than the children's at both time points, but also very positive; these differences were statistically significant. This difference could reflect a tendency on the part of the practitioners not to want to over-emphasise their own importance to the children with whom they work or it could be that workers did not fully appreciate the significance of their relationship for the child in the short period of time since the start of the intervention and the completion of the TASC at T1.

Alternatively, discrepancies in young people's and practitioner ratings could reflect differences in conceptualisations of 'alliance' between workers and young people (Ormhaug et al, 2015). By way of comparison, Ormhaug and colleagues (2015) compared therapist and youth ratings on the TASC and found that therapists similarly rated the alliance somewhat less positively than their adolescent clients. They suggested that adolescents appear to view the therapeutic alliance with their workers in more general affective terms, whereas therapists distinguish therapy work from relational bond. Ormhaug et al (2015) reported that adolescents whose therapists rated the alliance as relatively more positive than the adolescents showed less symptom reduction compared to dyads where alliance ratings were similar or more positively rated by the adolescent.

Figure 14: Practitioners' and children's therapeutic alliance Scores (min=12, max=48) Matched samples, older children and young people Intervention Group
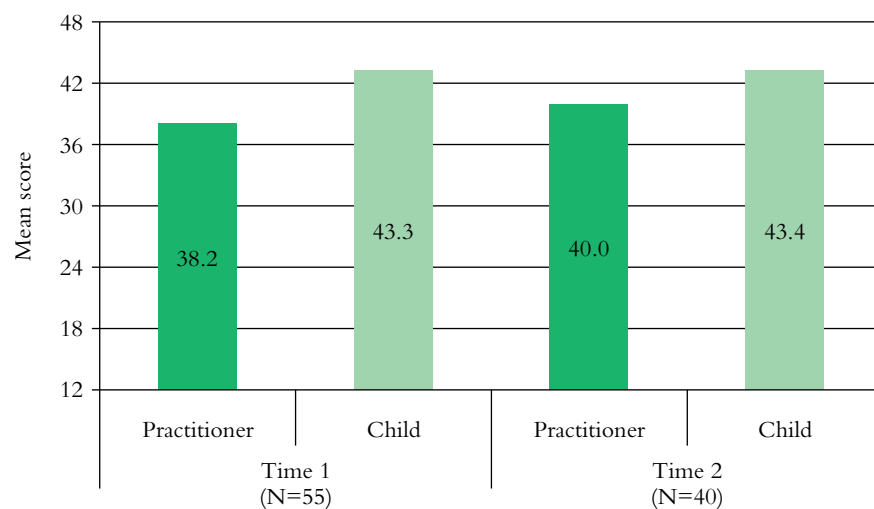

T1: Child vs Practitioner mean difference $t(54)=8.38$, p<.001
T2: Child vs Practitioner mean difference $t(39)=4.55$, p<.001

The children and young people evidently liked their practitioners (workers), feeling that they were on their side and that they were working together to deal with problems in the children's lives (see Figure 15 below). As the chart shows, the practitioners were also very positive in relation to all these statements, although a little less so.

Figure 15: Intervention Group: mean scores on practitioners' and children's TASC items at T1 (min=1, max=4) Paired samples, older children and young people (N=55)
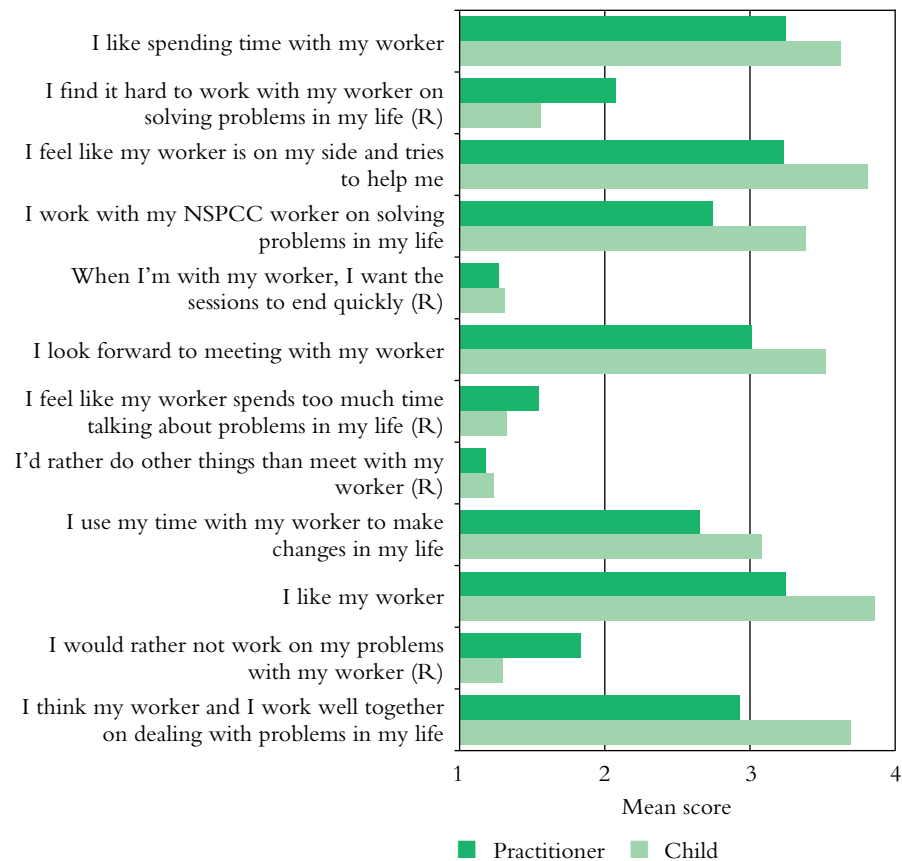
Note: 1=Not at all, 2=A little, 3=Mostly, 4=Very much. (R) = reverse scored items (Shirk & Saiz, 1992)

The children who responded to the questionnaire at the end of LTFI remained very positive: mean total scores T1: 43.72 vs T2: 43.87 and there was no statistically significant difference over time (t(38) = .312, p = .757). The practitioners gave statistically significant higher mean total ratings at T2 compared with T1: 40.27 vs 38.73 at T1 (t(36) = 2.44, p = 0.02).

These findings present a consistently positive picture of the therapeutic alliance from both sides. The baseline measure was taken after the third intervention session when it was evident that the practitioners had already built a very strong trusting and collaborative working relationship with the child. In other words, this was not something that had to be built up over a long time.

4. Outcomes for children and safe carers

4.1 Primary outcome for children and young people

In this section, we report the findings for children and young people over the first six months (T1–T2) in relation to the primary outcome, the change in the proportions who scored at the clinical or 'significant difficulty' levels on one or more of the subscales of the measures (TSCC or TSCYC). This is taken as an indicator of "caseness". We report clinical level scores and clinical plus significant difficulty scores. Because the TSCC is a child self-report measure and the TSCYC is completed by the carer, findings are reported separately for older and younger children[7].

We report the results for 'Analysis-Completers' (AC) first; these are participants in both intervention (intervention treatment) and waiting list control groups for whom we have baseline (T1) and six-month follow-up (T2) data. We then report the results of an intention to treat (Intention to Treat) analysis in which missing data are imputed statistically[8].

4.1.1 Older children and young people

There were no statistically significant differences between completers and drop-outs on any of the demographic variables. For the analysis completers group at baseline, the proportions of older children in the intervention and waiting list groups with at least one clinical level score were not significantly different: 57.1% (32/56 children) and 57.9% (32/57 children) respectively. The intention to treat analysis gave a similar, statistically non-significant result: 51.2% (42/82 children) vs 53.8% (43/80 children).

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7   In 12 cases, the child and the carer both completed measures. In these instances, we checked to see if the TSCC and TSCYC scores were 'valid' according to the instrument manual (for example, no evidence of age-related under- or over-reporting of symptoms). If TSCC scores were valid, we used these rather than the TSCYC scores.

8   Multiple imputation in this case was the statistical prediction of the missing score based on T1 score, demographics and variables suggested by previous literature to affect treatment outcomes, the nature of abuse (penetration or attempted penetration) and intra- or extra-familial abuse. Five imputations were run and a pooled estimate used.

For the analysis completers group at six-month follow-up, the proportion of children in the intervention group with at least one clinical level score reduced from 57.1% (32/56 children) to 35.7% (20/56 children). This difference was statistically significant (p = 0.029).

Of 32 children in the intervention group with clinical level scores at baseline, 19 improved to the extent that they were no longer in this range at follow-up and there was no change in status for 23 children. Considering children with sub-clinical/difficulty scores at T1, seven had moved into the clinical/difficulty range at follow-up and 13 remained below it. For comparison, of the 38 children in the waiting list group with clinical level scores at baseline, eight were no longer in the clinical range at follow-up and there was no change in status for 30 children. Of the children with sub-clinical scores at T1, five had moved into the clinical range at follow-up and 14 remained sub-clinical.

The equivalent intention to treat analysis showed a reduction from 51.2% (42/82 children) to 36.6% (30/82 children) for the intervention group, although this did not reach statistical significance (p = 0.065). For the waiting list group, just two out of 43 children were no longer in the clinical range, a statistically non-significant reduction. These results are presented below in Figure 16 (Analysis Completers) and Figure 17 (intention to treat).

Figure 16: Analysis Completers: percentage of older children and young people with clinical level scores on one or more TSCC subscales by intervention (N=56) and waiting list (N=57) group.
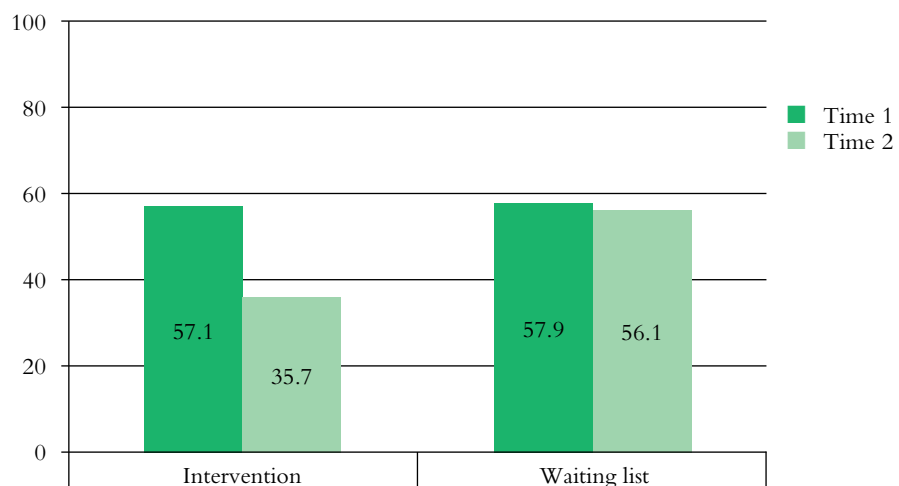
[McNemar Test[9] – Intervention p = .029, Waiting list p = 1.00]

_____

9   McNemar's test assesses the significance of the difference between two correlated proportions, in the case where the two proportions are based on the same sample of subjects or on matched-pair samples.
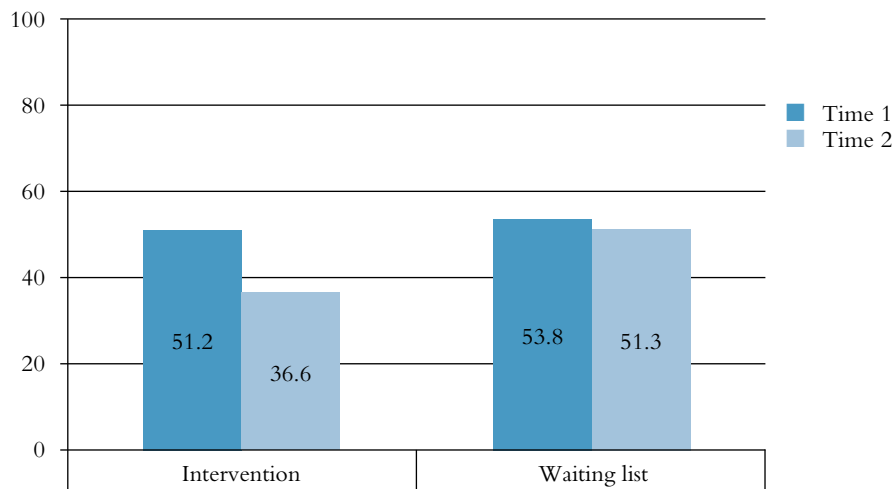
Figure 17: Intention to Treat: percentage of older children and young people with clinical level scores on one or more TSCC subscales (Intervention N=82, Waiting list N=80)
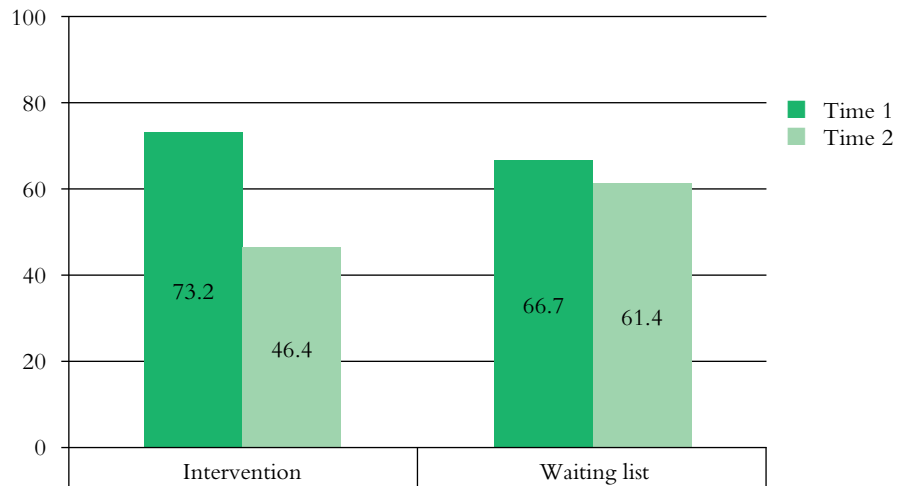

[McNemar Test – Intervention p = .065, Waiting list p = .839]

When we included the proportion of children with one or more significant difficulties, the baseline for the intervention group was 41 children (73.2%), which reduced to 26 children (46.4%) at follow-up, as shown in Figure 18 below. This difference was statistically significant (p <.001). Of 41 children in the intervention group with clinical plus difficulty level scores at baseline, 18 children improved to the extent that they were no longer in the clinical/difficulty range at follow-up and there was no change in status for 23 children.

Considering children with sub-clinical/difficulty scores at T1, three had moved into the clinical/difficulty range at follow-up and 12 remained below it. There was a much smaller and statistically non-significant reduction in the proportion with clinical/difficulty scores in the waiting list group (from 66.7% to 61.4%), representing an improvement for three out of the 57 children (see Figure 18).

Figure 18: Analysis Completers: percentage of older children and young people with combined clinical and significant difficulty scores on one or more TSCC subscales by intervention and waiting list control group (Intervention N=56, Waiting list N=57)

[McNemar Test – Intervention = .001, Waiting list = .581]

These findings were reflected in the Intention to Treat analysis, which showed a statistically significant reduction in combined clinical and difficulty scores from 68.3% (56 children) to 51.2% (42 children). See Figure 19 below.
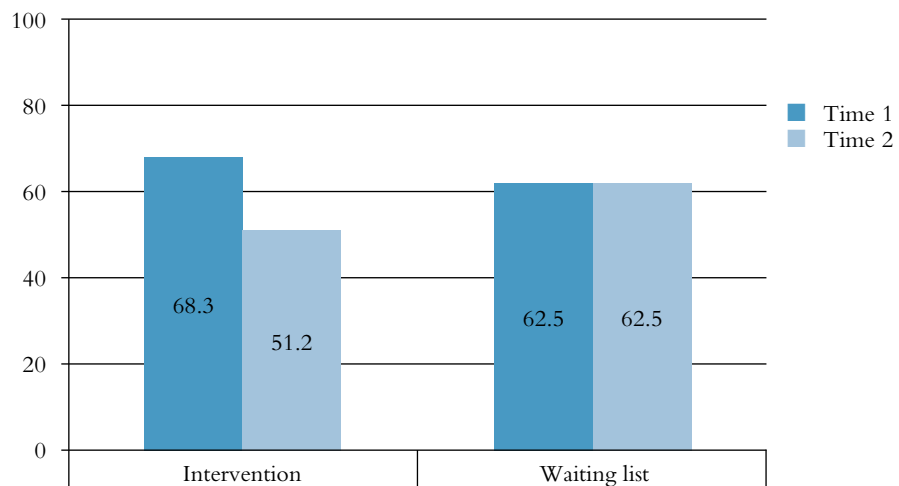
Figure 19: Intention to Treat: percentage of older children and young people with combined clinical and significant difficulty scores on one or more TSCC subscales by intervention and waiting list control group (Intervention N=82, Waiting list N=80)

[McNemar Test – Intervention = .016, Waiting list = 1.000]

TSCC subscale analyses

Figure 20 and accompanying Table 9 below show the results for each of the individual subscales for the combined clinical and significant difficulty ratings for the Analysis Completers. (These numbers are higher than the clinical scores alone and the statistical analysis is consequently more reliable).

Table 9 below includes the results of the statistical tests for the Analysis Completers group. This shows statistically significant improvements for the intervention group in psychological functioning, specifically in anxiety, post-traumatic stress and dissociation (general). There was also a reduction in the proportion of children reporting symptoms of depression, which was approaching statistical significance. There were no equivalent statistically significant changes for the control group.

Considering behavioural problems, the proportion of children self-reporting significant anger was low at baseline and this did not change. There was a reduction in the proportion of children self-reporting general sexual concerns in both groups but was only statistically significant for the waiting list control group.

Figure 20: Analysis Completers: percentage of older children and young people with combined 'difficulty/clinical significance' scores on TSCC subscales by intervention and waiting list control group (Intervention N=56, Waiting list N=57)
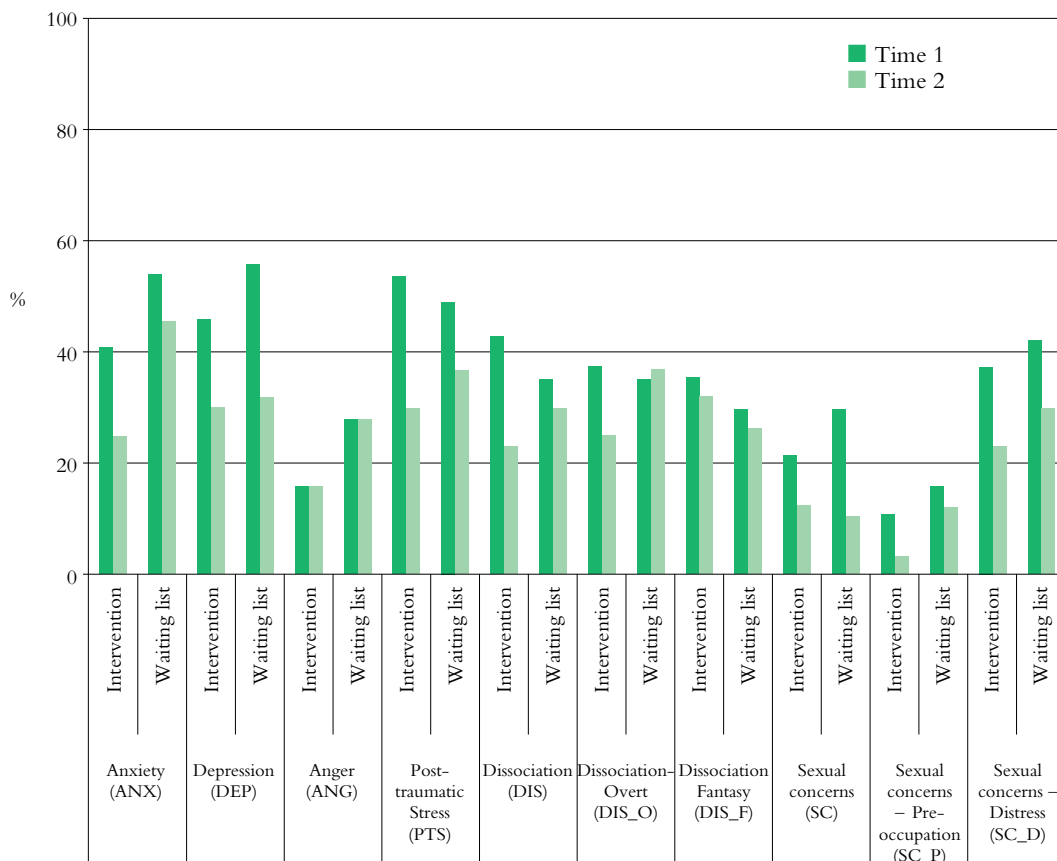
Table 9: Analysis Completers: Children with combined 'difficulty/clinical significance' scores on TSCC subscales by intervention and waiting list control group (Intervention N=56, Waiting list N=57)

TSCC subscale	RCT group	T1 (n)	T1 (%)	T2 (n)	T2 (%)	McNemar P
Anxiety	Intervention	23	41.0	14	25.0	0.035★
	Waiting list	31	54.0	26	45.6	0.227
Depression	Intervention	26	46.0	17	30.0	0.078
	Waiting list	25	56.0	24	32.0	1.000
Anger	Intervention	9	16.0	9	16.0	1.000
	Waiting list	16	28.0	16	28.0	1.000
Post–traumatic stress	Intervention	30	53.6	17	29.8	0.011★
	Waiting list	28	49.1	21	36.8	0.118
Dissociation (general)	Intervention	24	42.9	13	23.2	0.043★
	Waiting list	20	35.1	17	29.8	0.629
Dissociation – Overt	Intervention	21	37.5	14	25.0	0.167
	Waiting list	20	35.1	21	36.8	1.000
Dissociation – Fantasy	Intervention	20	35.7	18	32.1	0.824
	Waiting list	17	29.8	15	26.3	0.804
Sexual concerns (general)	Intervention	12	21.4	7	12.5	0.302
	Waiting list	17	29.8	6	10.5	0.003★★
Sexual concerns – Preoccupation	Intervention	6	10.7	2	3.5	0.289
	Waiting list	9	15.8	7	12.3	0.687
Sexual concerns – Distress	Intervention	21	37.5	13	23.2	0.096
	Waiting list	24	42.1	17	29.8	0.118

★ p=<.05, ★★ p=<.01

In the intention to treat analysis, there were statistically significant reductions in the proportions of children in the intervention group self-reporting psychological problems regarding posttraumatic stress, dissociation but not anxiety. In this analysis there was a reduction in the proportion in both groups self-reporting anger, which was statistically significant in the intervention group. Conversely, there was a reduction in the proportions with sexual concerns, which was statistically significant in the waiting list group (see Table 10 below).

Table 10: Intention to Treat: Children with combined 'difficulty/clinical significance' scores on TSCC subscales by intervention and waiting list control group (Intervention N=82, Waiting list N=80)

TSCC subscale	RCT group	T1 (n)	T1 (%)	T2 (n)	T2 (%)	McNemar (Two-Tail)
Anxiety	Intervention	29	35.0	22	27.0	0.210
	Waiting list	39	49.0	33	41.0	0.238
Depression	Intervention	32	39.0	26	32.0	0.362
	Waiting list	32	40.0	32	40.3	1.000
Anger	Intervention	41	50.0	23	28.1	0.003**
	Waiting list	38	47.5	28	35.0	0.076
Post-traumatic stress	Intervention	29	35.4	15	18.3	0.020*
	Waiting list	28	35.0	19	23.8	0.108
Dissociation (general)	Intervention	29	35.4	15	18.3	0.020*
	Waiting list	28	35.0	19	23.8	0.108
Dissociation – Overt	Intervention	28	34.2	19	23.2	0.122
	Waiting list	27	33.8	24	30.0	0.664
Dissociation – Fantasy	Intervention	24	29.3	20	24.4	0.557
	Waiting list	22	27.5	19	23.8	0.678
Sexual concerns (general)	Intervention	17	20.7	9	11.0	0.115
	Waiting list	21	26.3	9	11.3	0.008**
Sexual concerns – Preoccupation	Intervention	8	9.8	3	13.8	0.180
	Waiting list	11	13.8	7	8.8	0.289
Sexual concerns – Distress	Intervention	26	31.7	22	26.8	0.572
	Waiting list	32	40.0	26	32.5	0.327

★ p=<.05, ★★ p=<001.

4.1.2 Young children

The Analysis Completers group and drop-outs were very similar in terms of demographic and abuse characteristics[10].

Figure 21 below shows results for the 57 Analysis Completers on the TSCYC from carers. There was a very small reduction, from 88.9% (32/36 children) to 83.3% (30/36 children), in clinical ratings for the intervention group (Figure 21), and from 91.3% (42/46 children) to 87% (40/46) when the difficulty scores are added (not shown). In other words, just two children in the intervention group changed their status from clinical/difficulty to no problem. These small differences in proportions are not statistically significant.

Considering the waiting list children, there was no overall change, except that one child in the difficulty range at T1 was rated in the clinical range at T2.

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10 There was just one possible statistically significant difference between completers and drop-outs: one intervention group child had experienced extra-familial abuse vs two waiting list children, but the test result is unreliable because of very small cell counts.

Figure 21: Analysis Completers: percentage of carers reporting clinically significant scores for children on one or more TSCYC subscales by intervention and waiting list control group (Intervention N=36, Waiting list N=21)

[McNemar Test – Intervention = .687, Waiting list = 1.000, *small cell sizes]

The results of the intention to treat analysis were very similar, showing very little change in clinical and/or difficulty scores (see Figure 22 below). This translates to just two children in the intervention group and one on the waiting list becoming problem-free by T2.

Figure 22: Intention to Treat: percentage of carers reporting children with combined 'difficulty/clinical significance' scores on one or more TSCYC subscales by intervention and waiting list control group (Intervention N=46, Waiting list N=34)
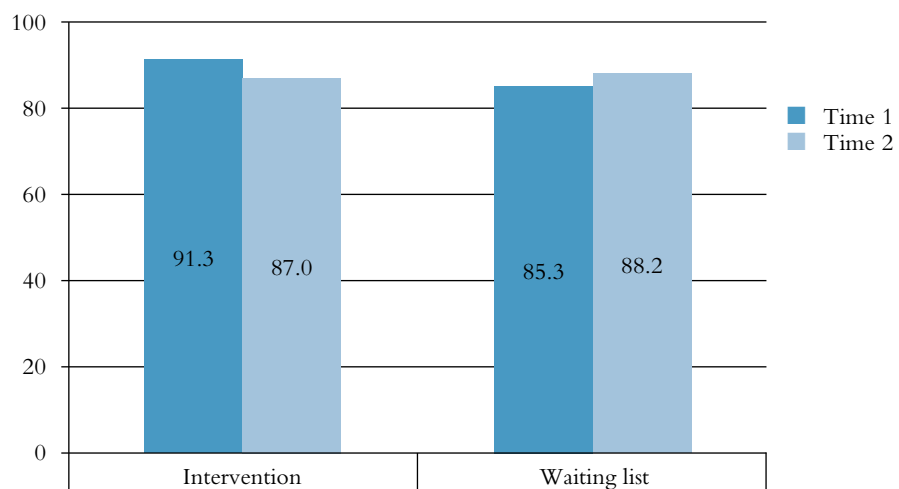
[McNemar Test – Intervention = .625, Waiting list = 1.000]

TSCYC subscale analyses

Considering the TSCYC subscales, there were statistically significant reductions in two of the nine subscales for the Analysis Completers group, both concerning dimensions of post-traumatic stress, "intrusion" and "avoidance" (see Table 11 below). These were also reduced in the intention to treat analysis, although the differences were no longer statistically significant (see Table 12 below).

By comparison, there were no positive changes in the waiting list group, and the proportions of children considered by their carers to have depression and to present sexual concerns had actually increased. In the context of little or no change overall, these results are not surprising.

Table 11: Analysis Completers: Carers reporting children with combined 'difficulty/clinical significance' scores on TSCYC subscales at T1 and T2 by intervention and waiting list control group (Intervention N=36, Waiting list N=21)

TSCYC subscale	Condition	T1 (n)	T1 (%)	T2 (n)	T2 (%)	McNemar p
Anxiety (ANX)	Intervention	24	66.7	18	50.0	0.109
	Waiting list	10	47.6	11	52.4	0.500
Depression (DEP)	Intervention	14	60.0	15	51.4	0.508
	Waiting list	13	38.1	7	61.9	0.125
Anger (ANG)	Intervention	17	47.2	14	38.9	0.453
	Waiting list	13	61.9	9	42.9	0.219
Post-traumatic stress – Intrusion (PTS-I)	Intervention	25	69.4	16	44.4	0.022★
	Waiting list	16	80.0	12	60.0	0.219
Post-traumatic stress – Avoidance (PTS-AV	Intervention	30	83.3	22	61.1	0.039★
	Waiting list	16	76.2	13	61.9	0.375
Post-traumatic stress – Arousal (PTS-AR)	Intervention	21	58.3	16	44.4	0.227
	Waiting list	8	38.1	10	47.6	0.625
Post-traumatic stress – Total (PTS-TOT)	Intervention	28	77.8	22	61.0	0.109
	Waiting list	14	66.7	11	52.4	0.250
Dissociation (DIS)	Intervention	17	47.2	15	41.7	0.727
	Waiting list	8	38.1	9	42.9	1.000
Sexual concerns (SC)	Intervention	19	52.8	19	52.8	1.000
	Waiting list	8	38.1	10	47.6	0.500

★ p=<.05

Table 12: Intention to Treat: Carers reporting children with combined 'difficulty/clinical significance' scores on TSCYC subscales at T1 and T2 by intervention and waiting list control group (Intervention N=46, Waiting list N=34)

TSCYC subscale	RCT group	T1 (n)	T1 (%)	T2 (n)	T2 (%)	McNemar p
Anxiety (ANX)	Intervention	32	69.6	24	52.2	0.057
	Waiting list	16	47.1	20	58.8	0.289
Depression (DEP)	Intervention	28	59.6	26	55.3	0.791
	Waiting list	14	41.2	23	67.7	0.022★
Anger (ANG)	Intervention	24	52.2	21	45.7	0.508
	Waiting list	22	64.7	17	50.0	0.227
Post-traumatic stress – Intrusion (PTS-I)	Intervention	32	68.1	25	53.2	0.143
	Waiting list	26	76.5	19	55.9	0.065
Post-traumatic stress – Avoidance (PTS-AV	Intervention	38	82.6	31	67.4	0.118
	Waiting list	25	73.5	22	64.7	0.549
Post-traumatic stress – Arousal (PTS-AR)	Intervention	27	58.7	21	45.7	0.180
	Waiting list	12	35.3	17	50.0	0.180
Post-traumatic stress – Total (PTS-TOT)	Intervention	36	78.3	21	67.4	0.267
	Waiting list	23	67.7	21	61.8	0.727
Dissociation (DIS)	Intervention	22	47.8	20	43.5	0.774
	Waiting list	14	41.2	16	47.1	0.688
Sexual concerns (SC)	Intervention	21	45.7	25	54.4	0.388
	Waiting list	14	41.2	21	61.8	0.039★

★ p=<.05

4.2 Secondary outcomes

The secondary outcomes for children were changes in the mean scores on the TSCC and TSCYC subscales. The analyses compared change in mean scores over time and between groups using an analysis of covariance (ANCOVA) – a statistical method that controls for the differences in the baseline scores.

There were no statistically significant differences on any of the subscales for either the older children and young people or the younger children. Note that the mean scores are derived from children and young people in the 'normal' range as well as those with clinical and difficulty scores. Tables of results are not included in this report.

4.3 Results of effectiveness analyses

These analyses were planned to assess whether children who received four or more sessions did better than those who dropped out early and for whom we had six-month data available. However, around 87% of children received four or more sessions, so it was not possible to detect any difference with the sample as a whole.

4.4 Follow-up: outcomes one year on for intervention group

4.4.1 Older children and young people

The intervention group was followed up six months after the T2 assessment, whether or not they were still receiving LTFI. Figure 23 below shows three groups of older children. The first (blue) comprises 34 children for whom we have data at all three time points. The red group comprises 22 children who completed the TSCC at T2, but not at T3. Finally, the green group consists of the 26 children who completed baseline measures who dropped out of the trial before T2.

The figure shows the proportion of children in each group with clinically significant scores at the different time points (where available). It can be seen that the proportion in the blue group dropped from 53% to 23.5% at T2, before rising to 44% at T3. Inspection of the intervention checklist (ICL) data showed that of the 34 older children and young people who self-reported TSCC scores at the difficulty plus clinical significance level at T2, 26 (76%) remained at this level at T3 (for example, not improving or 'worse' and were still receiving LTFI). The green group included a larger proportion of children without clinical scores at baseline; these completed LTFI or dropped out before the T2 reassessment.

Figure 23: Analysis Completers Intervention group: proportions of children reporting clinically significant scores on one or more TSCC subscales, Matched samples. (T1–T3) (N=82)
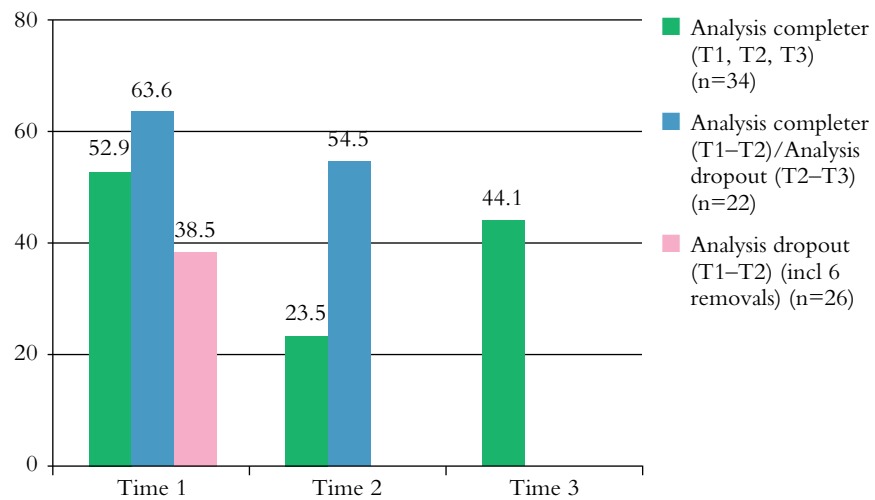
[Cochran's Q^{11} test = 8.316 p= .016]

We carried out an intention to treat analysis over all three time points, which adjusts for differential drop-out rates between groups. This suggested a statistically significant reduction in the proportion of clinical scores from 51.2% to 35.4% (T1–T2, p = .041) and a non-significant increase to 43.9% at T3 (p= 0.263). When the significant difficulty scores were included in the intention to treat analysis, a similar result was obtained (see Figure 24 below).

Figure 24: Intention to Treat analysis for Intervention group including follow-up: Proportions of children reporting combined difficulty/clinical significance on one or more TSCC subscales (N=82)
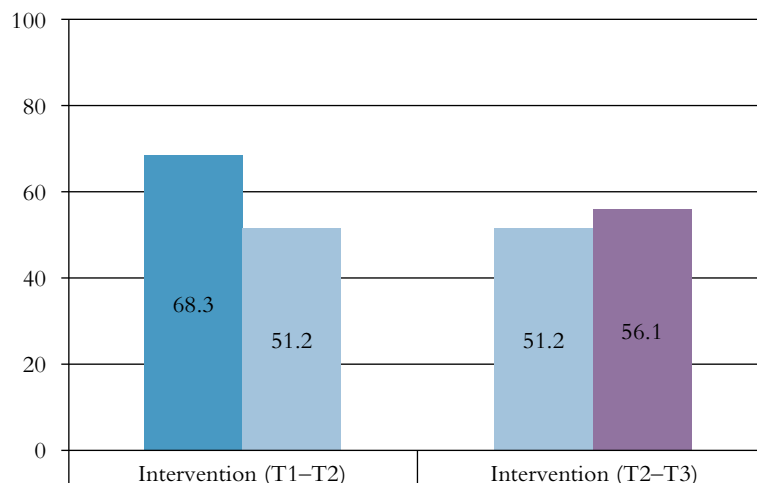
[McNemar test: T1–T2 p = .020, T2–T3 = .503]

_____

11 Cochran's Q test is an extension to the McNemar test for related samples that
    tests for differences between three or more matched sets of proportions.

Letting the Future In

4.4.2 Young children

The Analysis Completers analysis of TSCYC scores for the younger children found that, although the proportion of children with clinical scores had barely changed between T1 and T2, there was a reduction from 73.3% to 40% between T2 and T3, which was approaching statistical significance (p =.063) (see Figure 25 below). Note that the matched sample of Analysis Completers at T2–T3 was only 15 children. The intention to treat analysis of 46 cases is possibly unreliable because it was imputing data based on a small base; however, it does support this result, suggesting a statistically significant reduction from 87% to 22%.

Inspection of the ICL data suggests one possible partial explanation. The younger children for whom we have T3 data received more sessions on average (9.5) between T2 and T3 than between T1 and T2 (mean 7.0). This compares to the equivalent group of older children and young people who received a mean of 6.3 sessions between T2 and T3. In other words, LTFI seems to be spread over a longer period for the younger group and change may happen more slowly. It is also possible that the carers who rated the younger children may have taken longer to notice changes than the children themselves who completed the TSCC.

Figure 25: Analysis Completers Intervention Group: proportions of carers reporting children with clinically significant scores on one or more TSCYC subscales (T1–T2, N=36) (T2–T3, N=15)
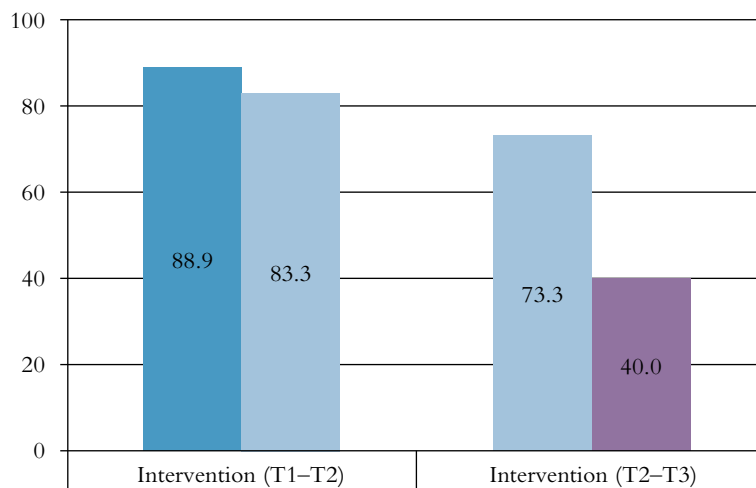
[McNemar: T1–T2 p = .687, T2–T3 p = .063]

4.5 Carers' support intervention

The effectiveness of the carers support intervention is an important secondary outcome of the evaluation. Table 13 below shows the proportion of carers (Analysis Completers) in the intervention and waiting list control groups with subscale scores on the Parenting Stress Index at or above the clinical threshold at baseline, T2 and T3. The threshold is defined as the 85th percentile. As shown in Table 13, there is little or no evidence of change in these scores between the baseline assessment and T2, six months later. The proportions are very similar at both time points in both the intervention and control groups, and the statistical tests confirm this.

There is evidence in the follow-up (Time 3) Analysis Completers' data of a statistically significant reduction in the proportion with clinical levels on the total stress score compared with T2 in both the intervention and the waiting list group (who were at this stage able to receive the intervention). This represents a reduction from T1 to T3 for the intervention group from 48.6% to 26.8% above the clinical level, and for the control group from 54.5 to 34.3%. There were no statistically significant changes in any of the subscales, either the proportions above the clinical level or the mean scores (tested by ANCOVA).

Table 13: Analysis Completers: Proportions of carers with 'clinical' level scores on Parenting Stress Index subscales (T1–T2 and T2–T3)

PSI Subscale		N	T1 n	T1 %	T2 n	T2 %	McNemar p	N	T2 n	T2 %	T3 n	T3 %	McNemar p
Parent–child dysfunction	IG	75	36	48.0	35	46.7	1.000	32	17	53.1	12	37.5	0.180
	WL	70	39	55.7	37	52.9	0.804	36	17	47.2	12	33.3	0.180
Parental distress	IG	73	19	26.0	19	26.0	1.000	30	6	20.0	2	6.7	0.219
	WL	70	25	35.7	23	32.9	0.804	36	12	33.3	8	22.2	0.344
Difficult child	IG	74	38	51.4	39	52.7	1.000	30	17	56.7	13	43.3	0.388
	WL	67	43	64.2	35	52.2	0.057	35	20	57.1	18	51.4	0.727
Total Stress	IG	72	35	48.6	35	48.6	1.000	28	15	53.6	8	26.8	0.016★
	WL	66	36	54.5	36	54.5	1.000	35	20	57.1	12	34.3	0.021★

★ p=<.05 The results for the intervention group according to analysis completion are illustrated below in Figure 26.

Figure 26: Proportions of parents with clinical level scores on the PSI
Total Stress Score – intervention group, matched samples. (T1–T3)
(N=115)
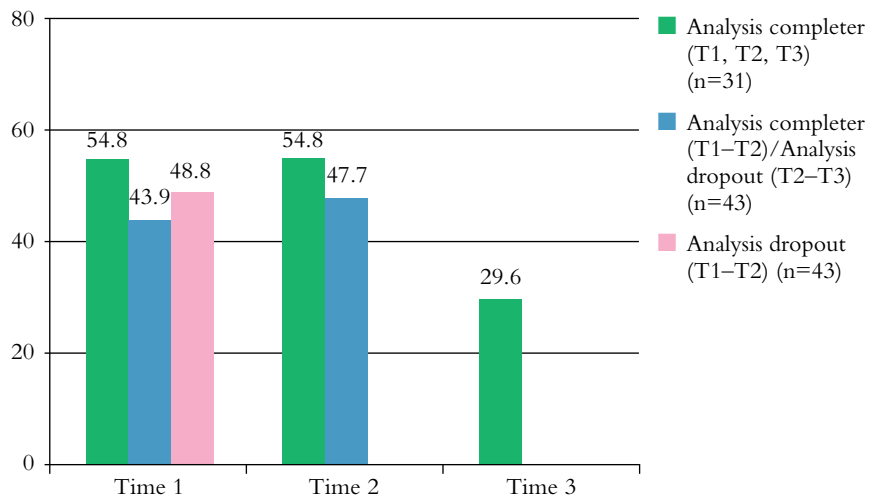
[Cochran's Q test = 7.200 p= .027]

5. Discussion of the impact evaluation

The impact evaluation employed the methodology of a randomised controlled trial (RCT) to assess the outcomes of the intervention for children and their carers. This approach had significant strengths and limitations.

5.1 Strengths

The most important strength of the impact evaluation is that the six-month outcomes for those receiving LTFI were compared with a control group created by a rigorous randomisation procedure. This was very successful in generating two closely matched groups for comparative analysis. The finding that, overall, the control group members did not change their clinical status indicated that changes in the intervention group were not due to the healing effects of time. This enables us to ascribe any differences between the intervention and control group to the effects of the intervention.

The randomisation procedure removed important sources of selection bias, effectively ensuring that practitioners and teams could not manipulate allocation to ensure that more 'needy' cases received the intervention rather than being placed on the waiting list. A further potential bias was reduced by the evaluation team being independent of the service and taking a neutral position in relation to the effectiveness or ineffectiveness of the intervention.

The research question that the evaluation was seeking to answer concerned the effectiveness of using LTFI in normal practice – in this case, NSPCC service centres. This 'real world' evaluation was, therefore, designed with a 'pragmatic attitude' (Zwarenstein et al, 2008). It was designed to be directly relevant to practitioners, managers and commissioners of services for children affected by sexual abuse, and the outcomes were assessed in terms of whether children and young people 'got better', defined as moving from a clinical/ significant difficulty level on a validated and standardised scale to having no clinical level problems or difficulties. There was only one exclusion criterion beyond that used for the intervention itself and this, the exclusion of siblings from the trial, was done for ethical reasons to ensure that they all received the same group allocation. A very high proportion of those eligible for the service (86%) consented to take part in the evaluation, suggesting that the participants were representative of those referred and eligible.

The total number of participants made this the largest RCT of a therapeutic intervention for child sexual abuse yet undertaken and it was significantly larger than all but one previously published trial. The participating children encompassed a larger age range than most previous trials (6–17 years) and comprised boys as well as girls. The number of participants was chosen in order to have sufficient statistical power to detect any measureable effects of the intervention. It also enabled us to deal with missing data and carry out an intention to treat analysis with imputation based on a substantial sample of complete data. The intention to treat analysis also drew on potentially important contextual data about the other forms of victimisation experienced by the children as well demographic and child sexual abuse related variables, such as the type of abuse and intra- or extra-familial abuse. By including children who did not engage with the services or who dropped out of LTFI early, the intention to treat analysis addressed the question about the effectiveness of a service and not just its efficacy for those children who completed the intervention.

The NSPCC teams that took part in the trial were not selected and neither were the staff who provided the intervention. In general, the practitioners were quite experienced in therapeutic work. All teams offering LTFI were potentially eligible, the only criteria for inclusion being that they had sufficient numbers of referrals to generate a genuine waiting list and that they had sufficient staff to deliver the service immediately for those in the intervention group, and also the capacity to follow up and provide a service to those on the waiting list. In the event, 18 out of 20 teams participated, further enhancing the generalisability of the findings because the children were drawn from different geographical settings, both urban and rural. Of the teams that did not participate at all, one had insufficient referrals over the data collection period and the other had staffing problems.

As discussed in more detail in the findings of the process evaluation (see Section 7.3.5), the intervention itself was applied flexibly, as it would be in standard practice, rather than according to a strict protocol, as in a study that compared the efficacy of different forms of intervention. The NSPCC did stipulate the maximum number of assessment and therapeutic sessions, although there was room for discretion at team manager level to extend these. In practice, this happened infrequently. LTFI was described as a "guide" to practice and beyond ensuring that eligibility criteria for the service was met and that the practitioners received supervision for their work, no attempt was made by managers to standardise the intervention within or across teams. It was for these reasons that we designed the Intervention Checklist to collect information about the number of sessions and types of interventions actually used. In addition, because the theoretical model assumed that the therapeutic relationship was a

'critical' factor, we collected information about that as well, from the perspectives of both children and practitioners.

5.2 Limitations

The most important limitation of the study was that the measured outcome period, T1–T2, did not encompass all the intervention sessions that the children received. This was especially true of the younger children. In other words, we are assessing in most cases the first sequence of the intervention only. Even among older children and young people, many were continuing to receive the intervention, and the outcomes at follow-up were difficult to interpret because the control group comparison was no longer available, having started their own intervention at T2. The unavoidable weakness of the waiting list control design in general was that the follow-up was necessarily short, although we did follow-up both groups for a further six months, enabling an uncontrolled comparison.

The choice of a six-month outcome period was mainly because the NSPCC and the ethics committee considered that this was the maximum acceptable for those children and their carers who had been put on the waiting list. However, we were guided by a meta-analytic review of 39 previous studies of therapeutic interventions with children affected by sexual abuse, which found that 30 interventions lasted for 20 weeks or less and that most demonstrated positive outcomes with this six-month period (Harvey & Taylor, 2010).

The second important limitation was that the outcome measures were self-report in the case of the older children and young people or proxy measures, for the younger children. For practical, financial and ethical reasons it was not possible to collect any observational or diagnostic interview data to substantiate the findings from the self-report measures. Both the TSCC and TSCYC scales include items designed to detect the under- and over-reporting of symptoms and behaviour problems. These indicated that the incidence of such responses was low. Nevertheless, the results from the two scales were quite different: thus, at baseline only 57% of older children gave clinical level ratings on one or more TSCC subscales compared with 85% of younger children who were rated by their carers. It is unlikely that this discrepancy reflects an actual difference in clinical condition; it is more likely to represent a difference in how children and parents were using the scales, not just at baseline but also at six-month follow up. There is evidence of under-reporting in some published studies using the TSCC (Butcher et al, 2013), suggesting that some older children and young people might be reticent to disclose their problems at the start of the intervention, possibly because they feel ashamed.

Conversely, parents of younger children might be inclined to over-report the occurrence and/or severity of their children's symptoms and behavioural problems. This might be reflecting their own anxiety about their child's experience of sexual abuse (which in some cases may have revoked unresolved issues about their own abuse). It might also, perhaps, reflect an understandable wish to ensure that the children get professional help. There is one other observation about the TSCYC: it asks the carers to report on the child's symptoms and behaviour over the previous month (only), but in practice it can be difficult not to recall earlier events as well. This may elevate T2 scores. The important point to remember is that the TSCYC ratings reflect the carer's own concerns, as well as their subjective assessment of their child.

Participants were not screened for clinical status at baseline, as required in many efficacy studies, which have the presence of PTSD alongside evidence of sexual abuse as core eligibility criteria. For example, Cohen et al's (2004) study required children to meet at least five criteria for PTSD according to the DSM-IV diagnostic framework. Considering the older children and young people in the LTFI evaluation, only a third had clinical level scores on the post-traumatic stress subscale. This limits the number of cases for which the potential of the intervention to achieve the primary outcome (the proportion moving from clinical to non-clinical status) could be demonstrated. This effectively reduced the statistical power of the study. However, it would not have been acceptable to the NSPCC to exclude these 'sub-clinical' children because they had, after all, been sexually abused, and referrers and carers were requesting help; also, it was not known whether these children would manifest clinical level symptoms or behaviour later on.

In addition to relying on self and proxy reporting, another potential source of bias was that the NSPCC staff who gave the TSCC and TSCYC measures to the children and carers to complete were not blind to the group status of the child (intervention or control) or to the time point (T1 or T2) at which data was being collected. In general, lack of blinding of staff making assessments is considered to influence scores (Miller and Stewart, 2011). However, a recent 'risk bias analysis' of 17 studies specifically concerned with CBT for traumatised children concluded that blinding or not had little effect with either interview or self-report measures (Rubin et al, 2016).

Finally, we should note Harvey and Taylor's (2010) observation that few studies collected any follow-up (post-intervention) data and, of these, even fewer followed up for longer than six months. There was anecdotal evidence from LTFI practitioners of children returning to the service months or years later because they felt they could benefit for further help, but this evaluation was unable to follow up

long term. We cannot say if a longer follow-up would have made a difference or if any effects identified in this evaluation will be long lasting.

5.3 Results

Outcomes were analysed separately for older children and young people (generally those eight to 17 years of age) and for younger children (generally under eight, but including some over eights who completed the TSCYC on the professional judgement of the practitioner).

Like many studies, especially those in an ordinary community service, attrition was significant: 28% of the intervention group and 27% of the waiting list group were lost to follow up at T2. In general, the larger the study the higher the attrition, and this compares with an attrition rate of 21% in the Cohen et al (2004) study at the same stage; this took place in two university hospital departments. As noted above, this is an important reason for using an intention to treat analysis in addition to analysis based on complete cases (Analysis Completers). We found that the results were consistent between analyses, although the intention to treat analysis was always a little more conservative because it included children who failed to engage and those who dropped out early without completing the intervention or the measures; these children may have more difficult family and personal circumstances.

5.3.1 Older children and young people

The results showed that over the six months outcome period for those who completed the measures on both occasions, there was a statistically significant reduction in the proportion of older children and young people with one or more *clinical level* problems who had received the intervention. In other words, a significant proportion of children (19 out of 32) moved from a clinical to a non-clinical status – in terms of the outcome, they had 'got better'. Over the same period, seven children had 'got worse', moving from a sub-clinical score into the clinical level. At the same time, there was no overall change in the control group and we are, therefore, able to attribute the improvement in the intervention group to LTFI, demonstrating that the intervention was effective. The intention to treat analysis, which is more conservative because it includes early drop-outs, showed a similar pattern of results, although these did not reach statistical significance.

LTFI was designed as an inclusive service and not just for these with clinical level problems but also sexually abused children with '*significant difficulties*'. When these children were included, nearly three-quarters (73%) of Analysis Completers at baseline were above the threshold. This reduced to less than half (46%) at six months, a statistically significant change. Overall, 26 out of 41 children (45%) with clinical/difficulty scores had 'got better'. This was reflected in the results of the intention to treat analysis in which the reduction was from 68% to 51%, also statistically significant. As before, there was no significant change in the control group. This provides further support for the effectiveness of the intervention, at least in the short-term (six months).

The subscale analyses of the TSCC found statistically significant reductions in the proportion of Analysis Completers with clinical/difficulty levels of 'internalising' symptoms associated with the effects of child sexual abuse, anxiety, post-traumatic stress and dissociation. There was also a reduction in depression, which did not reach statistical significance. The Cochrane review of randomised trials of CBT for child sexual abuse (MacDonald et al, 2012) concluded that the strongest positive effects (measured in terms of changes in mean scores at baseline and post-test) were for anxiety and post-traumatic stress, although the effects were only 'moderate'. The LTFI Intention to Treat analysis identified a statistically significant reduction in the proportion of children reporting 'anger', an 'externalising' symptom for which the Cochrane review reported mixed short-term outcomes.

As explained previously in Sections 1.5 and 3.6, the LTFI model places great emphasis on the therapeutic relationship as a vehicle for change and we hoped to examine this assumption quantitatively with the older children and young people as part of the impact evaluation (as well as in the process evaluation).

The children and young people's assessment on the TASC measure of their relationship with the NSPCC practitioner with whom they worked was outstandingly and consistently positive (see Section 3.6) and this was reflected in the qualitative interview data (see Sections 7.1.3 and 7.2.1). However, we were unable to distinguish between the effects of the therapeutic relationship and those attributable to the interventions suggested in the LTFI guide in determining these outcomes. This is largely because there was so little variation in the children's ratings of the alliance that were uniformly positive; consequently, there was no possibility of finding a statistical association between the strength of the therapeutic relationship and more or less positive outcomes. In any case, the LTFI model considers the relationship as well as the interventions used as essential ingredients for effective help. Our analysis showed that the children's ratings of the strength of the therapeutic alliance did not change over the course of

the intervention. This suggests that it was a moderator rather than a predictor or mediator of outcomes (see Section 3.6); in other words, that the alliance was likely to be a necessary, but not a sufficient condition for change.

The LTFI practice guide also proposed that practitioners develop an intervention plan based on an assessment made using the TSCC (and TSCYC) instruments (see Section 1.6). We will discuss the findings about the interventions used with both older children and young people, and younger children below. But first, we consider the children for whom LTFI was not effective in the short term.

At the six-month outcome period, over a third of older children and young people in the Analysis Completers and intention to treat analyses had clinical level scores on one or more subscales of the TSCC. Around half had clinical plus difficulty scores at the same point. We must remember that most of these children were still engaged in the intervention at six months, so it is perhaps not surprising that they still had problems at this stage. The follow-up six months later revealed a complicated picture in which participants had dropped out of LTFI and the evaluation at different stages (see Sections 4.4.1). This suggested that while some children with low baseline scores had dropped out early (before six months), 44% of Analysis Completers in the study at follow-up still had one or more clinical level scores. This latter group had not improved and in most cases was still receiving the intervention, presumably because they were reporting high levels of symptoms or problems.

For some of this group, the high self-reported scores might be associated with anxiety about the ending of the intervention itself and with it, the ending of a valued relationship with the practitioner. It is worth noting that some other studies have reported clinical level symptoms at the end of the intervention period (and others do not address this point). Thus, Cohen et al (2004) found that 21% of children who received trauma-focused CBT and 46% of the comparison group of children who received 'child-focused therapy' (CCT) were still diagnosed with post-traumatic stress at the end of the intervention. In other words, even at the conclusion of treatment in efficacy trials in controlled clinical settings, one would expect a significant proportion of children to continue to have clinical or significant difficulties.

5.3.2 Younger children

For the children aged under eight and those older children for whom the TSSC was not considered appropriate, the proxy outcome measure (TSCYC) was completed by the child's safe carer. As we have explained previously in Section 5.2, for practical reasons it was not possible to have an independent professional assessment of the child. We suggested that the TSCYC ratings reflect the carer's own concern as well as their subjective assessment of their child. This has implications for the findings as we consider below.

At baseline assessment, over 80% of the young children group was rated by their carers as having at least one clinical level subscale score, rising to nearly 90% when 'significant difficulties' were included. There was some evidence of statistically significant change in two of the subscales measuring post-traumatic stress for Analysis Completers, but this result was not maintained once the drop-outs had been included through the intention to treat analysis. However, both the Analysis Completers and intention to treat analyses gave similar overall results: no statistically significant changes in the proportions of children with one or more with clinical/difficulty ratings – just two children changed their status from clinical/difficulty status to 'no problem'. We have to conclude that for younger children there was no statistical evidence of improvement in clinical/difficulty status over the six-month outcome period, and no change in the control group.

We have suggested two possible explanations for the difference in outcomes between the 'younger children' group and the 'older children and young people' group in this impact evaluation. The first concerns the differences between the scales used to measure the outcomes, specifically who completes them. The two scales were developed by Briere and his associates, and designed to measure the same dimensions of response to post-traumatic stress. They are both standardised measures and we used the transformations recommended in the respective handbooks to account for age and gender before undertaking the analyses. But, our analyses yielded very different proportions of children above the clinical/difficulty thresholds. We cited above Lanktree et al's (2008) conclusion that a relatively small correlation between the relevant TSCC and TSCYC scales suggests that children and carers may have different perspectives on the child's symptoms and behaviour. Specifically, we suggest that the TSCYC ratings reflect the carer's own concerns, as well as their subjective assessment of their child. We know from the carers' responses to the Parenting Stress Index that at baseline almost half the carers reported clinical levels of stress (see Section 4.5) and that six months later there was no statistical evidence of change.

A second possible explanation is that assessment at six months was too early to identify change in young children. The Intervention Checklist data revealed that in the average case, the intervention was only approaching the half-way stage in terms of the number of sessions received by the younger children. There was evidence of a reduction in the proportion of Analysis Completers with clinical scores between T2 (73%) and T3 (40%), a result that was approaching statistical significance with a small sample. The intention to treat analysis indicated a statistically significant reduction, although we cautioned that this result may not be reliable. What it does suggest is that change occurs over a longer period in therapeutic interventions with younger children, possibly because it takes longer to assimilate cognitively compared with older children.

The two suggested explanations for the lack of change at six months are likely to act in tandem: the intervention for the younger children is more spaced out than for the older children and young people and may take longer, but it may also be that the carers take longer to recognise any change.

5.3.3 Outcomes for carers

The practice guide recommends offering up to eight sessions of a carers' support intervention (see Section 1.6.2). This is given by a different practitioner and in most cases is provided towards the end of the work with the child. With that in mind, it is perhaps not surprising that there was no evidence of change in the subscale scores of the Parenting Stress Index between the baseline assessment and T2, six months later. The subscales assess 'parent–child dysfunction', parental perceptions of their child as 'difficult', and 'parental distress'. Around half the carers reported clinical level scores on the first two scales; the proportions are very similar at both time points in both the intervention and control groups, and the statistical tests confirmed this. Parental distress was at a clinical level in around a quarter of respondents. There was a statistically significant reduction in the proportion of carers with clinical levels of 'total stress' for Analysis Completers at one year follow-up in the intervention group (from 54% to 27%), but we cannot necessarily assume that this was a result of the intervention rather than the passage of time.

An unanticipated finding from the analysis of Intervention Checklist data was that only 40% of carers actually received a carer's intervention. This did not match the NSPCC's expectations, but their own data suggests that the proportion is even lower for *all* families receiving LTFI – not just those in the trial. It is possible that some carers who did not receive LTFI were getting support from another agency. We have collected, but not yet analysed, this data.

5.4 Some conclusions

The impact evaluation of LTFI employed the methodology of a randomised controlled trial. In this instance, the trial was 'pragmatic', designed to test the intervention in 'real world' community services to see whether or not it made a difference to children who were referred and eligible (see Section 5.1). In this respect, its aims were different from those of the efficacy trials published in the literature, which aimed to test and compare the outcomes of manualised interventions in controlled clinical settings.

A recent paper by Rubin et al (2016) has discussed the challenge of implementing evidence-based interventions developed and tested through rigorous randomised controlled trials in 'everyday' practice settings. The results have frequently been 'disappointing' (p.1). As these authors discuss, various explanations have been offered, including lack of 'fidelity' to the treatment manuals, differences in the case mix of service users compared with those in the trials and contextual factors, such as more limited resources for training and supervision, higher caseloads, staff turnover and poorer attendance of service users in the community.

In addition to its size, the major strength of this pragmatic trial is its 'external validity'. Its findings reflect the real world of practice and have a high degree of generalisability. In other words, if LTFI were to be implemented in other services or locations, the outcomes should be similar, assuming the recruitment of equivalent staff, training and supervision. In these conditions, the evaluation has shown LTFI to be both highly appreciated by children affected by sexual abuse and, for older children and young people, to be relatively effective.

Rubin and his colleagues (2016) advocate the use of 'benchmarking' to improve the outcomes of community-based services. By this they mean assessing their outcomes (in a pre- post evaluation) and comparing them with benchmarks derived from aggregate 'effect sizes' obtained in published efficacy trials. There is much to commend in this approach because, as the authors suggest, areas for improvement can be identified and action taken.

In the LTFI impact evaluation, the suggested areas for improvement are in the outcomes for older children and young people where mean scores on the subscales across the intervention group as a whole did not change significantly. The benchmarks indicate that improvements could be achieved in depression, anxiety and trauma symptoms (Rubin et al, 2016) (see previous Table 3). Consideration could be given to practitioners' use of the range of interventions in the LTFI guide. Analysis of the Intervention Checklist showed that CBT, Trauma-Focused CBT and associated techniques, such as gradual exposure and scales and tools, were rarely used (see previous Table 8),

yet these are methods for which there is the strongest evidence base. This is not to advocate the use of CBT-based interventions instead of creative therapies, but to suggest that a better balance might be achieved and that this might lead to improved outcomes.

Similarly, the Intervention Checklist results suggested that other than age of the child, there was not much difference in the intervention being used according to the type of abuse the child had experienced or the perpetrator. This lack of differentiation suggests that intervention planning may not always have been based clearly on the results of the baseline TSCC/TSCYC scores and other elements of the therapeutic assessment. Again, this is something that could be reviewed.

For younger children, the LTFI six-month outcomes were disappointing, although there was some evidence of better outcomes over a longer period. An improvement programme would evaluate pre- post outcomes over the entire length of the intervention to see whether ratings reduced consistently. A qualification here is that the TSCYC outcome measure may have to be reviewed. However, findings from efficacy trials, particularly of Trauma Focused CBT, point to the importance of carer involvement and education in achieving positive outcomes over the short-term and in one-year follow-up (Cohen et al, 2004 and 2005).

In these efficacy studies, carer participation in the intervention was a *requirement*, a step up from the willingness and ability to support their child expected in LTFI. In the American efficacy trials of TF-CBT, the carer intervention was carried out at the same time and with the same frequency as the child's intervention. It was also shown to be effective in the short-term in reducing carers' stress. However, the timing of the safe carer intervention in LTFI needs some thought in the light of inconsistent findings from the family case studies reported below (see Section 7.2.4). Providing the same volume of service to the carer as TF-CBT would be difficult for the NSPCC with existing staff resources.

However, it is plausible that carer involvement is more important for positive outcomes in younger children than the older children, and the balance of resource might favour them. Again, programme improvement could use a benchmarking approach to check that outcomes for both children and carers improved following the modification on LFTI in this way.

6. The cost of Letting the Future In

6.1 Estimating the mean cost of the intervention

The unit (hourly) cost of LTFI was calculated according to the assumptions made by the Personal Social Services Research Unit (PSSRU) at Kent University for estimating the cost of children's social care. Staff work 35 hours per week for 260 days per year. Deducted from this are 37 annual and statutory leave days, and 8.2 days of sick/compassionate leave. This leaves 214.8 days. Ten days are allocated for training and professional development, leaving 204.8 days per year for case work and associated activities.

In 2013–14, the total salary costs for all NSPCC service centres were calculated as £2,880k and non-staff costs (premises, travel, printing and stationery, professional fees and grants, training, equipment and consumables, IT and phones) were £1,095k, giving a total of £3,975k. The service centres each delivered a number of programmes, including LTFI. The staff costs for delivering LTFI in 2013–14 were based on FTEs allocated to the service: children's service practitioners (CSPs) (51.7 FTEs), team managers (8.6), team administrators (12.9) and service managers (3.9). This gives a total of 77.1 FTEs each providing 204.8 days or 1,434 hours. The hours allocated to LTFI for the year were calculated as 110,531. Therefore, the unit cost (per hour) of LTFI was £3,975k divided by 110,531 = £35.96 per hour.

NSPCC Business Management estimated the mean time required per therapy session, including preparation, liaison with external colleagues, client contact, review, supervision and recording as 2.75 hours.

The mean total number of sessions per child was calculated from NSPCC data for all 1,423 cases seen by all teams delivering LTFI during the study period, not just those in the RCT. The total number of sessions recorded was 31,319. The overall mean number of sessions was 18.11, comprising 15.81 sessions of individual work including the child and a further 4.20 of work involving carers, joint sessions with children and carer-only sessions. In addition, a mean of 1.90 sessions per case was recorded as meetings with external professionals. The mean total cost was, therefore, 22.01 sessions x 2.75 hours x unit cost of £36 = £2,298 per child.

For comparison, the cost of delivering Functional Family Therapy for young people aged 11–18 with conduct disorder has been estimated as £2,555 per child (Khan et al, 2015)[12]. Parent–child interaction therapy for children aged two to 14 years costs around £1,800. Individual CBT for children aged 12 to 18 years with depression costs around £2,061. In other words, the mean cost of LTFI was quite similar to psychological therapies for other childhood problems. The average cost of cases with a range of mental health problems seen by a multidisciplinary Child and Adolescent Mental Health Services in the UK was estimated at almost £5,000 (PSSRU, University of Kent 2012).

Note that a cost-effectiveness analysis will follow in a separate report, together with information and costs of other services used by children and carers during the course of the study.

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12 Note that these costs were estimated using US data.

7. Process evaluation

7.1 The method

The aim of the process evaluation was to address two key research questions: how is *Letting the Future In* delivered, and what are key stakeholders' experiences and perceptions of the intervention? These were addressed by qualitative case studies at two levels: NSPCC team; and service user.

In addition, as the intervention guide notes, one of LTFI's fundamental premises is that at the heart of therapy is a therapeutic relationship, which endorses the principles and values of child-centred therapy and is characterised by "mutual trust and respect". The therapeutic model recognises both the considerable skills required by therapists to help children achieve change and also acknowledges the part that children affected by abuse play in their own recovery. As a result, the therapeutic relationship is seen as significant in assisting the engagement of young people and in the process of their healing. When the NSPCC commissioned LTFI, one of the stated aims was to add to the evidence base about the role of the therapeutic relationship in working with sexually abused children. In order to contribute to this aim, the evaluation included a specific qualitative study to explore the nature and quality of the therapeutic relationship developed during LTFI from the perspectives of people involved.

7.1.1 NSPCC team case studies

We undertook qualitative case studies of implementation with a sample of eight NSPCC teams delivering LTFI in order to explore in–depth issues around referral, delivery and perceived outcomes of the intervention. Within each team, in–depth interviews were conducted with key professionals involved in referral, delivery, management and ongoing monitoring of children and their families. These case studies were undertaken in two phases: four in 2013 and four in 2014.

Teams were purposively sampled, prioritising teams participating in the randomised trial of effectiveness where possible. Our sampling criteria included:

- *Diversity:* the NSPCC expressed particular interest in understanding whether LTFI was suitable for all groups including those from Black and Minority Ethnic (BME) backgrounds. The sample was determined by examining NSPCC data on all LTFI referrals since the launch of the service. We used data for children only (not safe carers). We compared ethnicity of referrals for individual teams to referrals across all teams.

- *Team experience:* to understand whether the guide was implemented differently in teams with more or less experience in therapeutic work with children affected by sexual abuse. The sample was determined by site visits in 2012 and throughput of LTFI cases.

- *Geographical area:* to explore whether implementation was affected by being located within large urban areas or working with a more rural population. We included teams with a mix of urban/rural catchment areas based on discussions with the team manager during earlier site visits.

In each team, we aimed to interview the LTFI team manager (TM) and at least one children's services practitioner (CSP – referred to hereafter as 'practitioner') delivering LTFI. We also planned to interview two external professionals who had referred a child to the service and could comment on it; however in the first year we had very limited success in recruitment and the quality of data was poor (as external professionals knew very little about the service). In the second year, we agreed with the NSPCC that we would instead interview two practitioners per team. Twenty-two interviews were carried out, mostly face to face, although the interviews with referring professionals were by telephone. Participants included six LTFI team managers, 12 practitioners and four referrers. Details of our achieved sample are shown in Table 14 below.

Table 14: NSPCC team qualitative case studies: sample details

	Diversity (% from BME)	Experience	Urban/ rural	RCT status	Participants
Year 1					
Team A	Low	Low	Urban	Joined after case study completed	TM (1) CSP (1) Referrer (1)
Team B	High	Medium	Urban	Joined after case study completed	CSP (1)★
Team C	High	High	Urban	Yes	TM (1) CSP (1) Referrer (2)
Team D	Low	High	Urban	Yes	TM (1) CSP (1) Referrer (2)
Year 2					
Team E	High	Medium	Urban	Yes	TM (1) CSP (2)
Team F	High	Medium	Urban	Yes	TM (1) CSP (2)
Team G	Low	Medium	Rural	No	CSP (2)
Team H	Low	High	Urban	Yes	TM (1) CSP (2)

★ The team manager was on unplanned long-term absence during the case study period, hence no interview and no referrer contacts provided.

7.1.2 Family case studies

We also undertook qualitative case studies of children and young people who had received the intervention to better understand: the acceptability of the intervention to users and their views of the key elements of the intervention as they have experienced it; whether the programme was delivered as intended in specific cases; and possible causal pathways from programme receipt to outcomes. Within each case study, we aimed to include the perspectives of children and young people, their safe carers and the NSPCC team member(s) delivering the intervention.

We invited a random sample of participants from service centres taking part in the evaluation. Our target sample was 15 case studies with a child who had experienced child sexual abuse and had received the intervention, and their safe carer. We targeted closed cases only and did not approach participants mid-intervention in order to avoid disrupting the therapeutic process. This meant that although children received a service from teams participating in the RCT, in most cases they had begun the intervention before the RCT trial had begun and hence were not part of it. In the first instance, we targeted cases that had been closed for at least six months, in order that children and carers would have had time to reflect on the intervention and its perceived impact on their lives.

We achieved our target sample of 15 case studies and interviewed 16 practitioners, 17 carers and 12 children in total. The children and young people ranged in age from 5–18 years and received their final session of LTFI between August 2013 and September 2014. Five of the 15 were male, and all were White-British.

Details of the achieved sample of children, carers and practitioners are in Table 15 below. Most interviews with carers were conducted face to face in the family home, but where participants preferred it, some were carried out by telephone. All interviews with children were in the family home, and where children requested it, with their carer present.

Table 15: Family qualitative case studies: sample details

Case Study No.	Child's age at time of case study (years)	Child's Gender	Interviews		
			Child	Carer(s)	Practitioners
1	5	M	_	Mother	CSP for child CSP for carer
2	12	F	Yes, with carer present	Grandparents	_
3	18	F	Yes	Mother	CSP for child
4	11	M	Yes	Mother	_
5	6	M	_	Mother	CSP for child
6	16	F	Yes	Mother	CSP for child
7	12	F	Yes, with carer present	Father, with child present	CSP for child CSP for carer
8	7	F	Yes, with carer present	Mother	CSP for child CSP for carer
9	10	F	Yes, with carer present	Mother	CSP for child
10	11	F	_	Mother	CSP for mother
11	13	F	Yes, with carer present	Mother	CSP for child
12	15	M	Yes, with carer present	Mother	CSP for child
13	10	F	Yes, with carer present	Mother Father	CSP for child
14	15	F	Yes	Mother	CSP for child
15	14	M	Yes	Mother	CSP for child

7.1.3 Therapeutic relationship study

Three teams that were not engaged in other qualitative elements of the evaluation (such as the team or family case study elements) participated in the therapeutic relationship study. In each participating team, four young people, their safe carers and the relevant practitioners were sought to take part in a qualitative, semi-structured interview.

Participation comprised a two-step opt-in process for young people and their safe carers. Information about the study and a 'consent for contact' letter was passed by the participating teams to young people who had completed the LTFI programme. Where families agreed to be contacted by the researcher, additional consent forms to participate in an interview were then completed with individuals. Consent was obtained from all young people to talk to their parents or carers and the practitioners who worked with them.

The semi-structured interviews with practitioners, carers and young people were guided by topic guides. The first question for all participants was "Tell me about working with ...worker/young person/parent". Subsequent questions focused on specific phases of the relationship (beginning/ending); how the relationship changed over

time; activities, techniques and tools used in sessions; what it was like talking to someone about difficult things; and change.

Eight families and their practitioners took part. In total, 26 people were interviewed in the course of 24 interviews. Two were joint interviews, one with a couple (parents) and the other with a young person and her carer.

As it was possible for young people to choose not to take part but to agree that their carer could be interviewed (or vice versa), the number of interviews conducted over the eight cases varied. Interviewees were all White British and comprised six young people (all female), seven parents (six female, one male) and 13 practitioners (11 female, two male) who had worked with either the parents or young people concerned. Young people interviewed ranged in age from 11–18 years at interview and most had completed the intervention within the previous six months.

The researcher had no access to case files and did not ask questions about children's background or the details of the abuse, although some knowledge of abuse circumstances was gained during the interviews as a result of young people's own statements. Three young people had been sexually abused by adults in their family. Two young people were sexually abused by peers. The remaining young person had been sexually abused and exploited by someone in her neighbourhood. Nine interviews were held in the service users' family homes, one in an alternative venue, 14 in an NSPCC service centre and the remaining two were conducted by telephone by participant choice.

7.2   Experiences of receiving LTFI

7.2.1 Therapeutic relationship

Interest in the role of therapeutic relationships in facilitating change is longstanding. A range of studies have investigated the nature of the 'therapeutic alliance' between therapist and client, and its association with outcomes (Chiu et al, 2009; McLeod, 2011; Shirk et al, 2011). A number of tools have been developed to measure the strength of therapeutic relationships, including the Therapeutic Alliance Scales for Children (TASC) (Shirk & Saiz, 1992) as discussed previously in Section 3.6. Evidence suggests a modest association between a positive therapeutic relationship and therapeutic outcomes for young people (McLeod, 2011). However, research with both young people and adults has tended to focus on how to measure therapeutic alliance rather than to address questions about the qualitative nature of interactions in therapy from participants' perspectives. There is evidence that adolescents are well aware of their problems and desire

change, in which case therapist–adolescent consensus on goals may be crucial (Zack et al, 2007; DiGiuseppe et al, 1996). On the other hand, Faw et al (2005) suggest that it is the bond element of the therapeutic relationship that is most important for young people.

Although there is increasing interest in participatory research seeking children's perspectives on their experiences and the services they receive, prior qualitative exploration of sexually abused children and young peoples' personal experiences of recovery processes and of relationships in therapy is limited (Foster & Hagedorn, 2014; Carroll, 2002; Jensen et al, 2010). The current study aimed to fill this gap, in addition to presenting findings on TASC scores as detailed previously in Section 4, by additionally interviewing a small number of children and young people, their parents/carers and the practitioners involved about their perspectives on the relationships they developed in their engagement with LTFI. The qualitative findings presented here, therefore, build on the quantitative findings reported in previously in Section 4.

Unlike much previous research, the current study sought the perspectives of all individuals involved in a child's therapy and is, therefore, able to offer a holistic view of the relationships developed in a therapeutic intervention in a small sample.

Young people
Young people invariably reported positive relationships with their workers, though the majority said that they had some reservations before therapy began. None of the young people had experienced therapy before they were referred to LTFI or knew what to expect. They thought they would have to talk about their abuse and felt anxious. However, young people said that they began to feel a connection with their workers at an early stage of the intervention. Practitioners were skilled at putting young people at ease in their initial meeting and this first contact was important in influencing young people's willingness to take part. They described worker attributes as "*reassuring*", "*warm*", "*friendly*", "*honest*" and reported that they fairly quickly felt "*comfortable*" or "*relaxed*". Young people particularly valued the understanding that sessions would be private and confidential:

> "Like the way that she said that everything would be confidential, she wouldn't say anything and to prove that I'd get to take everything home at the end, which I did." (YP5, aged 11)

Two young people noted positive differences between their workers and other professionals with whom they had contact (social worker, counsellor), indicating that any barriers in place as a result of previous less satisfying relationships with professionals were overcome. The speed with which young people began to engage with and trust practitioners is noteworthy given that the nature of the abuse they experienced involved a significant betrayal of trust.

Established therapeutic relationships were characterised by young people as involving continued trust and growing familiarity, and choice in the pace and direction of the therapeutic work. As relationships progressed, young people emphasised that their workers became more like "*friends*" – in one case a "*sister*" and in another "*another mum*" – although these were qualified descriptions as they also made it clear that they knew the difference between friends in their worlds outside therapy and this 'friend' in therapy sessions. Nevertheless, the sense of a "friendship" quality was present in most cases:

> "...she was like one of my best friends" and "like a best friend really, like a sister. Always looking out for me." (YP9, aged 15)

> "...more like we were friendly towards each other as well, and kind of we had, um, what you call close, as close as a friendship you can have with someone that you have that kind of professional relationship." (YP2, aged 17)

The availability of real choice was valued by all young people interviewed, particularly in the context of tasks or activities. Young people participated in a range of "therapeutic" tasks and all reported that as time went on they felt able to refuse to engage in activities. They also enjoyed sharing with their workers activities that were just fun ("*general chat*", "*painting and drawing*", "*Monopoly*") and that may have served both to relieve emotional tension and to consolidate the therapeutic relationship. Choice represents a lessening of power differentials, a move towards equality in relationships, and gives to young people an element of control over what happens to them. For children whose abuse was disempowering and took away their control, this is an important part of the relationship.

Faw et al (2005) suggest that one dynamic that may differentiate young people's therapeutic relationships from those of adults in therapy is a particular emphasis on bond compared with tasks and goals. While this study cannot confirm this proposal, it is clear that the **relational qualities – safety, trust, confidentiality and caring – were important to young people's continued engagement** with their worker. Young people had their own motivations for engaging with therapy – some clearer about goals than others – but

there were emotionally challenging times in the intervention when attendance was more precarious, noted particularly by young people who described going through a trauma-processing phase. At these times, young peoples' trust and faith in their workers – the sense that workers were "*looking out for*" them, and creating possibilities for positive change – were important.

The ending phase of therapeutic relationships was important for young people. All said that they were prepared for this and were mostly ready to finish, but nevertheless they felt a sense of sadness at losing a special person in their life. Each of the young people had become comfortable and familiar with the routine and with their workers, and felt some anxiety about leaving the NSPCC. However, **endings were positive events for young people**, because they were able to take away with them tangible reminders (pictures, activity books) and intangible ones (breathing exercises, new interpretations of events, new understandings of themselves). They were able to see how their lives had changed in their worlds outside therapy and thus recognise that the original purpose for intervention no longer existed:

> "...at the very beginning I was quite – not in a very good place, I don't think I thought about aims in the future, but then probably when I got to a better place, my aim was probably just to feel a lot kind of freer, that's probably the right word, to feel a lot lighter and freer probably about things." (YP2, aged 17)

Practitioners

Like the young people, **practitioners reported positive and strong relationships** with young people and carers receiving the LTFI intervention. All felt that a good working relationship was essential in order to help effect change with both young people and parents. Importantly, practitioners' perspectives on relationships were congruent with the views of young people; the relational process described by practitioners corresponded with service users' perspectives.

Practitioners understood how young people were likely to feel at the first meeting, and they **emphasised skills in listening, attunement, and sensitivity to moods, emotions and observed changes**. Workers used what children described as personal qualities (*warm, nice, friendly*) together with considerable skills to help engender feelings of comfort and trust in the early stages of the relationship.

Establishing routines was seen as important by practitioners and the value to young people was demonstrated in their reports of the comfort and reassurance derived from having a familiar space, familiar things, and a familiar person. Practitioners were clear that they would not attempt to work with a child's trauma until they believed that the child felt safe and strong enough to do so.

Planning for sessions varied, but all practitioners were prepared to alter plans once the child arrived, focusing on what the child brought to the session. Practitioners recognised that this approach would help young people have choices, feel empowered and in control, feel that their worker cared, feel listened to, and have a voice within the relationship:

> "She kept me on my toes, she really did because she was driving it really, which was brilliant, so I mean I just really respected that in her, that she was able to do that and knew what she needed." (Practitioner, YP5)

Endings were also important to practitioners. They were able to celebrate changes made by young people and carers but **they experienced loss following the ending of a close relationship**. For practitioners, part of this loss was that they would not know for sure whether young people would be all right in the future, whether change would be sustained, whether new problems might emerge. Practitioners said that they appreciated having worked with each child and felt that they had gained experience and learning from each relationship:

> "Every client you have is different, you learn something new from them... I suppose in a sense that's the beauty of the work, it's that you never ever quite know what is going to happen, what it's going to be like. And I suppose that's why I love it really, it's always really very fresh. You know, you don't really get two days the same or two sessions the same." (Practitioner, YP1)

Parents and carers

Parents and carers were interviewed, both about their relationships with their own practitioners, and their perspectives on the relationship between their child and her worker. As parents and carers were not offered a *therapeutic* service, there was less emphasis on developing a therapeutic relationship. However, parents expressed similarities to young peoples' reports in both the process and nature of relationships that were developed.

All **parents said they observed strong and effective relationships between their children and their workers**, had themselves good working relationships with children's workers, and additionally expressed without reservation their gratitude for the service received and the changes they saw in their children. Given that it is accepted that building relationships with both parents and children in these circumstances presents challenges to practitioners, this finding is important.

Among the relational elements that carers valued in their own workers were professional knowledge and experience, help to support the ongoing work with their child, and emotional support and practical parenting advice offered to them. In common with young people, parents who developed particularly strong relationships with their own workers noted positive **practitioner attributes and characteristics of care, personal attention, openness, and trust.** Three parents referred to the importance of feeling at ease with workers and of not feeling judged – an important relational ingredient in working with parents who may carry a profound sense of shame or guilt as consequences of their child's sexual abuse:

> "I found her fantastic and very easy to talk to, she makes you very comfortable, and you can tell she cares as well, you can just tell, she's very kind. And she made me at ease. Because going into this, obviously there's feelings of like are you going to get judged yourself, for not being there at the time, which is a massive thing for me." (Parent, YP5)

Summary

It is likely that young people and parents who were satisfied with the LTFI service were more willing to agree to be interviewed. Therefore, the findings may not be representative of the full range of therapeutic relationships experienced by service users who received LTFI. However, the experiences of this small sample illustrate the critical role for service users and workers alike of positive relationships as a core element of the intervention. All the young people described a relational process that started with uncertainty and anxiety, consolidated over time into a special relationship characterised by trust, sharing, mutuality, confidentiality and care, and ended with a celebration of change but also a sense of loss. YP9 summed up the process in three sentences:

> "When I first met her, I don't think I really liked her, but then as I got to know her, I started to get on with her, and I really liked her. When I found out she was leaving...I nearly cried. Because she was like one of my best friends." (YP9, aged 15)

7.2.2 Children's experiences of the intervention

Practitioners interviewed as part of the family case studies reported using a range of approaches during sessions with children and young people. Younger children had a strong element of play in their sessions, and were also more likely to have used books and stories. Older children experienced a wider mix of approaches, including creative arts and drawing/painting, written work, role-play and talking directly about their feelings and experiences. All of the practitioners reported adapting their approach according to the needs of the child.

Both children and practitioners were asked about the most important element of the work and 'critical sessions' for the child. Dealing with feelings about the alleged perpetrator of the abuse was most likely to be mentioned. Practitioners reported that allowing the child to freely express anger towards the perpetrator was very important.

Children also commonly made mention of creating something, such as a diary, as a reminder of the progress they had made. This was something that they valued.

Some children clearly recalled techniques they had been taught to deal with overwhelming feelings of anxiety and/or anger, which they had practised during sessions and still used at the time of interview.

Other critical sessions dealt with overcoming the child's sense of guilt and blame; being able to describe the abuse again and deal with it openly and calmly; and being able to talk freely about the abuse they had experienced.

The children and young people interviewed reported no dissatisfaction with any aspect of the intervention. All were very positive about the service they had received and were able to self-report a range of impacts that they attributed to the service. The most frequently mentioned was **being less withdrawn** and more able to interact with others, in particular family and friends. Children mentioned the benefits of opening up and becoming more confident in company. Linked to this was a **reduction in guilt and self-blame** for the sexual abuse:

 "Back then I was quieter than usual and I was scared to talk,
 I was scared to do things but she taught me that I could talk,
 I could do things, and she taught me that it wasn't my fault."
 (FC13 child)

Some children also mentioned **reductions in depression and anxiety**, and two specifically mentioned **improved sleep patterns**.

In all cases, there was evidence of a strong therapeutic relationship between children and their practitioners, as reflected also in the findings of our separate study of children's experiences of the therapeutic relationship (see Section 7.2.1). Children spoke highly of their practitioner, and important attributes included being warm, friendly, cheerful, caring, welcoming, perceptive, and genuine. Children also valued being listened to.

Children reported trusting their practitioner, though this could take time to develop. It was reinforced by the confidential nature of the relationship. Trust could also be influenced by their carers – *"people who mum trusts, I trust" and s*ome children told us that talking to their practitioner helped protect their carer:

> "I felt like I needed to talk to someone but not my mum because I didn't want to upset my mum or have to put things more and more on her shoulders." (FC6 child)

Children were also likely to value confidentiality because of past experiences with other professionals, like social workers. All of this contributed to children reporting that they could talk openly in sessions.

7.2.3 Carers' experience of the intervention their child received

Similarly, carers were positive about the service their child received and in particular about its impact on family life. This was often felt very strongly and comments like *'It was a lifeline'* or *'they saved us'* were common. The most important factor that contributed to carers' satisfaction with the service their child had received was seeing their child recover from the effects of sexual abuse. Other factors included the service centre environment, feeling supported, the child's reaction after attending, seeing their child develop a strong bond with the practitioner, good communication with the child's practitioner and careful preparation for ending the service.

Perceived impact on the child

Carers were unanimous in reporting that the service had had a positive impact on their children and most were able to identify specific changes that they attributed to LTFI. In one family, the carers reported a stark improvement in their child's **developmental level**, which they attributed to LTFI, having tried several other services previously with little success.

Almost all carers made mention of their child's **improved mood** since attending the service. For most, this was evident through their child being happier, laughing more frequently, and expressing positive thoughts about the future. Two carers witnessed the cessation of self-harming behaviour and suicide ideation in the children. Many carers mentioned that **their child was less angry** when talking directly about the sexual abuse. They also noted that aggression directed towards them, siblings, and/or within the school setting had reduced. Some children were described as **more outgoing after the intervention**.

Several carers had felt 'shut out' from their child, and worried that the child no longer talked to them about their thoughts and feelings, either about the sexual abuse or more widely. This changed for many families after the intervention, with **carers reporting that their child opened up again**.

Carers also enjoyed **seeing their child become more confident**.

All carers who mentioned **problems with sleeping** as one of the impacts of the sexual abuse on their child said that this had improved post-intervention. Children were more able to go to sleep alone, and were less disturbed by nightmares.

Two carers of very young boys expressed a clear desire that their child learnt to distinguish 'right from wrong' when it came to **sexual behaviour**. This had two aspects; learning how to protect themselves from further sexual abuse, and not displaying any harmful sexual behaviour towards others. Both carers felt that the NSPCC had successfully addressed this:

"He thought that that was a normal behaviour from other boys and that's what other boys wanted, so I wanted him to believe that that is not normal and what had happened was totally wrong. I think, by the end of the sessions, he knows that, he knows it's wrong. He knows he can tell people. [Practitioner] had done something with him, if something had happened, he can shout, "No," and she said that he'd be shouting it so loud and now he knows, "No." (FC5 carer)

Some carers described their child as **much less anxious and stressed** post-intervention.

Service centre environment

Most children received a weekly session so the location of the service was important. For some carers this meant having a service centre that was easy to get to. Where it was not, or carers could not take time away from other responsibilities, some practitioners would collect and return the child. In other cases, the service was delivered outside the service centre in a location nearer the child's home, such as a local children's centre. One carer also valued a discreet location, situated in a quiet street '*so nobody sees you going in and out'*.

Once there, many carers commented on how welcoming the service centres felt. This was in part attributed to the physical environment, including child-friendly decoration, but more commonly to the attitude of NSPCC staff. Carers reported being made to feel comfortable by all staff, and that they mattered:

> "At the reception they were brilliant…nothing was too much trouble, there was always a word for the children. You didn't feel you were being fobbed off." (FC2 carer)

Feeling supported

Some of the carers in the study reported feelings of relief and comfort after their child began the intervention because they had an additional source of support. Often, this reduced their feelings of isolation.

> "I didn't ever feel I was on my own, they were the only people we have ever phoned in 20-odd years…they were always there." (FC2 carer)

Several carers had also received support from the practitioner to help deal with other agencies in the child's life, most commonly schools.

Reaction of the child after attending sessions

Many carers said that their child's behaviour immediately after therapeutic sessions was a reassuring sign that they were beneficial. Children were described as coming out of sessions more cheerful, 'lifted' and tellingly by one mother, '*like a normal child'*.

Relationship between the child and practitioner

All carers reported that the child developed a good relationship with their practitioner, and identified several characteristics of the practitioners that enabled this. These included continuity, particularly where children had previously experienced numerous brief contacts with staff from different agencies. Also important was being friendly and warm, and approachable. Other characteristics included making the child feel safe, building trust, and encouraging the child to talk openly. Carers noted that practitioners demonstrated all these

characteristics *quickly and* their child 'clicked' with the practitioner almost immediately.

Good communication with the child's practitioner

Confidentiality was a key factor in the relationship between the child and practitioner, and most carers in the study understood the need for this. Several carers knew that that their children were protecting them from upset by avoiding talking about the sexual abuse and its impact. They did not want the practitioner to disclose the content of sessions in case this prevented the child from talking freely. One admitted she appreciated not knowing the full details:

> "[Practitioner] did say that this was primarily a confidential relationship between her and him, which I was fine with, because in lots of ways hearing what had happened to her was making me worse." (FC11 carer)

Carers *did* want to know whether their child was making progress and in most cases were happy with the way the practitioner was communicating this to them.

Preparation for closing

Many carers reported feeling anxious about the child's response to the intervention's end, but in almost all cases they were happy that the child had been well prepared for this by the practitioner. Often this was done using visual countdown tools, making clear in advance how many sessions were left:

> "[the child] doesn't react well to things suddenly stopping. You can never say 'right we are going now', but if you say 'five more minutes' then she's fine with that. [Practitioner] had a glass jar with marbles and they counted out the sessions left by taking marbles out of the jar and that approach was perfect for [the child], she could plan for the end." (FC10 carer)

Carers were less likely to report problems or concerns about the service, but some did emerge. Some of these are mirror-images of the positive aspects described above, such as the child's reaction after sessions, feeling excluded, and disappointment with the impact on the child.

Child's reaction after sessions

A few carers reported that their child came out of sessions in a low mood or visibly upset. In one family, the child had a very extreme reaction to sessions, described by her carers as '*horrendous – defiant, abusive, aggressive*'. This was difficult for carers to witness. In addition, it could result in disruption to children's education, either because

they simply could not go into school that day, or it would be very difficult for them to engage. In all cases where children had a poor response after sessions, carers reported that this was more common during the early phases of the intervention and stopped happening as the child became more used to attending. In addition, carers who had reported concerns about their child's response also said that the practitioner had responded:

"In the beginning she was going earlier and then going back to school and I said I don't like her going back to school while she's feeling all these emotions, …That's why we changed the sessions to the afternoon and then that's why at the end of each session, you had your silly five minutes, didn't you? That changed it, because at the beginning I could see she was really coming home in a very upset mood, but after your silly five minutes you were coming home quite okay, weren't you?" (FC13 carer)

Feeling excluded

One parent reported that she did not have enough information about her child's progress and would have welcomed more frequent updates:

"You feel a wee bit left out…[   ]… I would get the parents more involved, maybe an extra couple of meetings with the parents. I know they can't elaborate on what they go into in their meetings, but just maybe that, would be nothing else. I kept focusing in my head as long as she was okay, and as long as she was talking to somebody." (FC3 carer)

Return of symptoms

In two cases, the progress that the child had shown was not sustained after the intervention ended and the child had been referred for more support. In the first case, at the time of interview the child had begun to re-experience symptoms of anxiety and had recently been referred to CAMHS for further support. The carer, child and practitioner all agreed that the intervention had ended too soon, because meaningful work was only beginning to happen when the case was closed. All felt that there were organisational pressures on the practitioner to close the case after the child had received 26 intervention sessions:

"It's exactly because she stopped at a point where she wasn't ready to stop…[practitioner] cannot go against the organisation, can she? She cannot say, "Well, listen, this kid is needing more counselling, and I'm going to give her more counselling," because she has to obey the rules that are within the organisation." (FC14 carer)

In the second case, the child's depression had returned post–intervention and his GP had prescribed anti–depressants. Neither carer nor child attributed this to the intervention ending too soon and had re-contacted the NSPCC for further support from the same practitioner, which was granted.

Narrow focus

Two carers felt that the service was too focused on the effects of sexual abuse and ignored other difficulties. These could be challenges faced by the child or the carer. In one instance, the carer felt that his child had problems forming normal friendships at school and was causing upset by describing her experience of sexual abuse to her peers. He would have liked the NSPCC to address this. The second carer was involved with the Family Court attempting to prevent the alleged perpetrator having contact with her child, and was disappointed that the NSPCC would not allow her to cite the child's TSCC results to support her case.

7.2.4 Carers' experiences of carer intervention

Practitioners reported that a key use of carer sessions was to address carers' needs to talk about the abuse and deal with their reaction to it. They described some carers as traumatised and wanted to use the sessions to help them process their own thoughts and feelings. Carers who engaged with the service were also likely to mention being unable to talk with friends or family about it and needed what one carer described as an '*emotional safe space*'. They wanted help in understanding their response, and to process their thoughts and feelings:

> "We needed someone to tell us what we were thinking wasn't wrong. We were allowed to think those things, we were allowed to feel those things." (FC4 carer)

Carers also reported struggling with feelings of guilt that they had not been able to protect their child from sexual abuse. Some described feeling like 'incapable parents' or 'failures'. These feelings were particularly strong in families where the perpetrator was a relative and strongest when it was a step-sibling. Many carers recalled how helpful the sessions had been in dealing with this guilt:

> "[Practitioner] said even though it happened to [child], husband and I were victims as well. And I didn't think of myself as a victim, I thought of myself as an unfit mother." (FC9 carer)

For practitioners, dealing with this trauma and guilt was key in supporting the carer to meet the child's needs, particularly to help them communicate better with their child. Practitioners also reported using the sessions to help carers understand and manage their child's behaviour. This could mean managing anger and aggression, supporting the child's confidence and self-esteem, and helping reinforce messages about keeping themselves safe from further abuse.

Many carers were described as needing reassurance about their parenting skills, following on from a dramatic loss of confidence after the disclosure of abuse. Carers reported receiving useful advice on coping with challenging behaviours, such as aggression, rebellion, and withdrawal, and strategies learned during sessions had helped at home. Some carers also wanted help to repair their relationship with the child, which they felt had been damaged by the disclosure of sexual abuse. Several carers told us they had lost the ability to be 'normal' with their children and the sessions helped address that.

Several reflected on the socio-educative element of sessions where they had learned about grooming and how to protect the child from further abuse. Carers also needed reassurance that there would be no 'lasting effects' of the abuse.

One mother had disclosed her own child sexual abuse for the first time in carer sessions and the practitioner felt this was making her more anxious about her daughter's future. Two mothers of young sons were particularly anxious that they would have learned abusive behaviour, and discussions about normal and age-appropriate sexual behaviour helped with this.

However, carers could also feel undermined by their child's practitioner and practitioners would use the sessions to assuage their anxiety:

> "I think Mum was very anxious about [the child] coming here. I think she found it very difficult, her coming to another person, and I think Mum felt quite a bit of loss of control, and felt that she wanted to be the one. I tried doing a lot of reinforcement with Mum, that she is the main person in her child's recovery, and tried doing a lot of reassurance, really, that she plays a big part in her role." (FC8 practitioner)

Carers and practitioners also reported using the sessions to discuss relationships with partners, in particular improving communication between parents, and managing wider family relationships.

Several respondents raised concerns about the timing and number of carer sessions as currently set out in the guide. Some carers felt that because the sessions were so helpful, they would have preferred to have started them earlier so that they could have received more of them. One carer felt that the delay in starting carer sessions meant that she could not benefit from them because she had formed a habit of suppressing her own needs and prioritising her child's:

"It was like I needed [carer sessions] before. My way of dealing with the emotions – at the time, I felt that I had to put them away and [child] was the priority. So by the time I [started], this would have been a few months into [child's] work, I didn't want to open up." (FC10 carer)

Similarly, another mother reported feeling unable to open up during carer sessions, but in her case she felt this was because the sessions started *too soon*, before she was ready to talk about what had happened.

Practitioners also told us that they would have liked more sessions with carers, because in many cases carers had other issues beyond child sexual abuse that they wanted to address, including bereavement, relationship breakdown, and in one case their own history of child sexual abuse. One practitioner told us that where carers were willing and motivated to engage with the work, it was especially difficult to limit the number of sessions to eight. In some cases, however, they did acknowledge that this may be all that is needed.

Most carers attended sessions at the same time as their child to make life easier with regard to childcare, transport and time. Both carers and practitioners acknowledged this could place limitations on the carer sessions. Firstly, it meant that sessions could be shortened as the carer helped settle the child into their own session and be ready to meet them afterwards. But the greater issue was that seeing the child immediately after the session meant that both carers and practitioners were keen to avoid any risk of the carer appearing distressed:

"There are lots of times when kids are in and parents are in at the same time. You are very conscious that you don't want this parent leaving the room in a really distressed state. Not that you ever want them to leave in a distressed state, but you're conscious, too, that your session can be interrupted, and of how fair that is on the mum or the dad to try and get themselves together to be this parent that can hold this child's worries and have those broad shoulders when they're processing their own emotions." (FC1 practitioner)

"My sessions were at the same time as [child's] and I was always very conscious that I would have to be there for her when she came out of hers and possibly pick her up if it had been a hard session. So I was preparing and keeping myself for that really, so I didn't want to go into all that with [my practitioner]." (FC10 carer)

Summary

Findings from the family case studies demonstrate a high level of satisfaction on the part of those children, young people and carers who took part in interviews. Although the sample is relatively small and the purposive sampling strategy used means that we cannot know whether these positive experiences were shared by all families receiving LTFI, the findings from this element of the evaluation suggest that LTFI is acceptable to children and carers alike. Therapeutic relationships were valued highly by service users, and carers, in particular, were able to see positive changes in their children, which they attributed directly to the intervention.

7.3 Implementing LTFI

7.3.1 Small teams in NSPCC service centres

There were eighteen teams involved in the delivery of LTFI at the start of the evaluation, with two more joining mid-way through. Teams generally comprised an LTFI project team manager and between 2–7 practitioners delivering LTFI. Practitioners were usually also involved in delivering other NSPCC commissions.

7.3.2 Profile of practitioners

We undertook an online survey of NSPCC staff involved in the implementation of LTFI across all teams at the beginning of data collection for the RCT. We received 98 responses, of which 17 were managers of LTFI practitioners and one was the service manager of an NSPCC centre. The remaining 80 were children's services practitioners delivering LTFI to children, young people and their carers. We report the results from those 80 practitioners here (14 of whom were male).

Professional qualifications and experience

The majority of practitioners delivering LTFI had a qualification in social work (88%) with some also holding qualifications in therapy (39%) or counselling (26%). The practitioners were experienced, with 80% holding their professional qualification for more than six years (and 36% for more than 16 years). Many also reported undertaking additional (non–certified) training in one or more therapeutic

approaches (58%), and 72% had at least six years' experience of direct work with children affected by sexual abuse.

Self-efficacy ratings

Practitioners were asked to indicate on a 5–point Likert-scale how much they agreed or disagreed with a series of statements about their capacity to deliver LTFI. Most respondents (93%) agreed that they were clear on their roles and responsibilities in working with children using the LTFI guide, and the same proportion agreed that they had a good understanding of local inter-agency procedures on safeguarding children who have experienced sexual abuse. Almost all (92%) agreed that they could describe the complex range of potential impacts of sexual abuse on girls. This figure was marginally lower for boys (90%). A large majority (86%) agreed that they had the skills to elicit psychological change with children and young people (eight (11%) were unsure and two (3%) disagreed), and all but two newly appointed staff reported feeling confident in their ability to communicate effectively with children about their experiences of sexual abuse.

Staff interviewed during team case studies

Almost all of the NSPCC staff interviewed were trained social workers, and most had done some additional training in therapeutic work. During team case study data collection, two teams were being supervised by a temporary manager, and one team manager was relatively new in post (18 months). The remainder of the respondents had worked for the NSPCC for between four and 26 years, and in most cases in a therapeutic role for some or all of that time.

7.3.3 Training provided for LTFI

Staff allocated to LTFI are required to attend a three–day NSPCC course on the LTFI guide; all of the respondents interviewed during the team case studies had attended, though views on the usefulness of it were mixed. As recommended in the guide, all the practitioners interviewed had also had therapeutic training. Overall, this group of respondents were very experienced in therapeutic work with children.

Staff also had regular regional practice development days that brought practitioners from several teams together to focus on specific aspects of the guide. Development days could include input from external experts as well as offering an opportunity to share good practice across teams. Most respondents had attended at least one of these days and felt that the training provided there had been useful, as well as being an opportunity to learn from experienced practitioners in other teams.

Practitioners were keen to continue to learn and improve their practice. All expressed a desire for more ongoing training and development opportunities than were currently being offered.

7.3.4 Acceptability of the LTFI practice guide

Timescales and structure of intervention

Practitioners were broadly positive about the LTFI practice guide and the structure it had brought to their therapeutic work with children. Practitioners who were experienced in this type of work tended to comment that the guide had not changed their therapeutic approach in any fundamental way, but that it had introduced a structured framework that still allowed enough flexibility to respond to individual children's needs. For them, this combination of structure and flexibility was seen as helpful.

Many practitioners found the content of the guide comprehensive and practically useful. Particular mention was made of the guidance on assessment of the full range of issues that may be affecting the child. Practitioners also found the components of the intervention suggested by the guide to be a useful list of areas to cover (helping child tell their story, socio-educative work, sexually inappropriate behaviour, power relationships, identity and self-esteem, awareness and management of feelings about sexual abuse, and integrating traumatic experiences). Experienced practitioners were likely to say that they would have covered all this anyway; however, some felt it had given them renewed confidence in their practice and in some cases helped to focus their work. The content of the guide was felt most useful for inexperienced practitioners provided they used it flexibly.

Most respondents also liked the guide's limitation on the number of intervention sessions to twenty (with a maximum of thirty in exceptional circumstances). This had stopped cases going on for too long and encouraged a more focused approach than was previously in place. Where concerns were raised around the number of sessions for children, these were limited to 'unusual' cases that, according to respondents, did not easily fit even into thirty sessions. Practitioners reported that a small number of cases had gone on for longer than 30 sessions. High levels of trauma were most commonly cited as the reason that cases would go over the recommended timeline; other reasons included complexity (including around family dynamics and history of sexual abuse), change of practitioner mid-way through the intervention, shifting court dates and at the request of external agencies.

Practitioners also reported that it was not unusual for cases to close earlier if the work was completed before 20 sessions. Cases were also closed earlier if the service was not seen to be effective and needed to be referred to an external agency (commonly CAMHS) or the child no longer wanted to take part. Non-engagement, where the child missed sessions frequently or did not appear to want to be there, was a frequently reported cause of 'drop-out', and this was more likely to happen with older young people. For most cases, however,

endings were prepared, with practitioners working with the child to plan towards stopping the service. This often involved a review of the work to date and progress made towards the goals agreed with the child (few practitioners used the resolution template included in the guide).

Safe carer work

The main concerns expressed about the LTFI guide focused on the restrictions practitioners felt were placed on safe carer work. Assessing the carer as 'safe' and in a position to support the child in therapy had proved difficult on occasions and some practitioners were concerned that this criterion was leading them to turn children away who may have benefitted from the intervention. This was linked to the timing of the work with safe carers, with some practitioners suggesting that if they could have more flexibility to work with the carer and in some cases the wider family first, this would allow them to stabilise the home environment and proceed onto work with the child. In many cases, this view was influenced by previous ways of working, as some practitioners reported previously being able to do more work with carers first and offering a greater level of intervention.

Safe carers were reported to often be struggling with the impact of discovering their child's sexual abuse, coping with an ongoing relationship with the perpetrator (especially if another child), wider difficulties in family functioning and/or ongoing child protection issues. For some carers, the abuse had evoked difficult memories of sexual abuse that they had experienced themselves. These issues often overlapped. While practitioners understood that the aim of the intervention with carers was to help them understand and support the child and not to provide therapeutic support for their own needs, many found this difficult in practice. Managers were clear that carers who needed additional support should be referred elsewhere, such as to GPs, other therapeutic counselling, mental health services and family therapy services. However, these services may not be available locally or may have long waiting lists.

Many practitioners also felt that the guide did not allocate enough sessions to do meaningful work with safe carers, especially in cases where they felt it was necessary to deal with a carer's own trauma before they could concentrate on the needs of the child, or where there were two carers involved. Conversely, other practitioners felt that eight sessions, as suggested by the guide, was enough time to complete the work. Indeed, they reported that in many cases they did not use all of these sessions. However, both practitioners and managers would have welcomed more flexibility in the number of sessions allocated where there were two safe carers who wished to be involved, and/or when more than one child in the family had been sexually abused.

Finally, it was suggested that there were also a considerable number of cases where practitioners had been unable to engage the safe carer at all. Reasons for non-engagement of safe carers included that they thought the service should be focused only on the child, they did not want to explore their own or their family's response to the sexual abuse, or were traumatised by their own experiences of sexual abuse. Some teams also mentioned that foster carers may be less likely to engage.

7.3.5 Fidelity

In this section, we address the extent to which team practice was in accordance with the protocols in the LTFI practice guide. The team case studies suggest that, in the main, the structure of the intervention was consistent across teams and with the guide.

Practitioners were using the assessment model described in the guide. Respondents were generally positive about the therapeutic assessment process and reported few problems. They frequently cited the usefulness of the assessment template and the headings within as supporting them in covering the full range of issues that may be affecting the child. The assessment sessions were primarily used to assess whether or not the child was 'ready' for intervention. Practitioners were clear that not all children and young people should proceed further than the assessment stage. Most were happy that four sessions were sufficient to complete a full therapeutic assessment.

Most practitioners wrote an assessment report that was then reviewed by and discussed with the manager, carers and the child. Practice appeared to vary in how these assessments were then translated into an intervention plan and how that plan was used. Not all practitioners wrote a formal intervention plan, but all prioritised agreeing a set of goals for the intervention with the child and would record these.

The LTFI guide outlines several components that should be included in the intervention with the child, including helping the child tell their story, socio-educative work about sexual abuse, sexually inappropriate behaviour, power relationships, identity and self-esteem, helping children manage their feelings about the impact of the abuse and integrating traumatic experiences. It suggests an order, but also states that practitioners can use their professional judgement if their assessment of the child's needs indicate that they should deviate from this. Most practitioners reported being very flexible and 'child centred' with the order in which the intervention components are covered in sessions. This will mean that the 'phasing' is not always consistent with the guide.

Some reported that several areas could be covered in a single session and children would 'go back and forth', making ordering the intervention components tricky. In addition, practitioners reported that when using play therapy it was not always apparent during sessions what was happening therapeutically:

"I also think sometimes, particularly when children use play, it's not until you reflect on the session that it becomes clear about what has been going on. You think about the areas, because sometimes I think, 'I'm just not sure what area that comes into to be honest. What was happening there?' For me, it's the process of then writing up the session that makes me reflect and think, 'Okay, that's quite clearly about power relationships, or issues about control'." (Practitioner, Team H)

However, while practitioners were often flexible with the order, most were positive about the guidance on the components that should be included in the intervention stage, helping give the intervention a structure and ensuring that they covered all the necessary areas. Particular mention was made of socio-educative work and integrating traumatic experiences as being key to the intervention.

Experienced practitioners reported that the implementation of the guide had not significantly affected their therapeutic approach. This is to be expected and it is encouraging that practitioners report being able to tailor their approach to suit the needs of the child. The LTFI guide was developed by an NSPCC practitioner group with a range of backgrounds and extensive experience of working therapeutically with children affected by sexual abuse. As such, it is not a 'new' model but one that is informed by staff experience. It is unsurprising then that none of the respondents who had previously worked with children affected by sexual abuse felt that the introduction of LTFI had changed their therapeutic approach to working with children affected by sexual abuse in a significant way. Most reported using a range of methods across both directive and non-directive work, adapting to the needs of the child, as the guide suggests.

There is no sense that the introduction of LTFI has impacted on therapeutic practice other than the structure of the intervention. Even those practitioners who strongly identified with a particular method (for example describing themselves as play therapists) reported using a range of methods according to the needs of the child, and that this is was what they had always done. For most, although LTFI had not influenced the therapeutic method used, it had added value to the content and areas covered.

There were a small number of practitioners across both years who remained strongly sceptical about the use of the guide (and indeed the implementation of all NSPCC commissions), seeing this way of working as too "reductionist" and structured, and inhibiting child-centred therapeutic work.

7.3.6 Use of the guide with children from BME backgrounds and children with disabilities

Some of the teams had had few or no referrals for children and young people from BME backgrounds. In several teams, respondents thought this was because the local population was very largely White British. Respondents in other teams whose catchment area included a substantial BME population also had few such referrals and considered that they could be better at 'reaching out'. One practitioner felt that her team would benefit from being more ethnically diverse to better reflect the population they were working with:

"We have no Asian workers… You need to target it, we need to target that community but you need the right sort of people to target that community and the right sort of workers." (Practitioner, Team F)

Teams with more experience in working with BME groups reported few difficulties. Practitioners were clear that there was nothing in the LTFI guidance that would impede working with minority groups, but rather that it would be down to the individual practitioner's experience and understanding of cultural differences. In particular, respondents noted that in some cultures, there may be difficulty talking openly about sex and relationships with non-family members:

"The guide asks you to be very open with the child in the beginning about what's happened, and I think in some communities that would probably be too difficult…" (Team manager, Team H)

"There's a culture where you don't really talk about things outside of your family. I think because of that, [Mum's] been reluctant – …[   ]…I think that's hindered the work. …[   ]… Some of that is culturally about because it was perpetrated by a male, and about how that is considered in their culture." (Practitioner, Team E)

Respondents were all clear that LTFI presented no barriers to children (or carers) affected by a physical impairment, although they had had few such referrals. In general, practitioners felt that such disabilities could always be accommodated with the right support. Views on the suitability of LTFI for children with learning disabilities were more

varied. In most teams, managers were exercising judgements on a case-by-case basis on whether the child was capable of benefiting from LTFI. Since the team case studies were undertaken, the NSPCC has developed an adapted version of LTFI for children with learning disabilities, which is currently being piloted.

7.3.7 Challenges

Pre-trial cases

All teams had experience of working with children when the alleged perpetrator was facing an ongoing prosecution, but their confidence in working with pre-trial cases varied hugely. For some teams, it was presented as a problematic issue. The main concern of practitioners in these teams was that they had to exercise care in what was spoken about in pre-trial sessions, focusing more on feelings and impact than talking directly about the nature of abuse the child had experienced. Some practitioners felt anxious about overstepping these boundaries, but in the main appeared to be managing them well. Some noted that the limitations on what can be covered in detail in pre-trial sessions, together with the work required to support the child in preparing for the trial, meant that LTFI was delivered in a different way with these cases. This may mean that outcomes for the child are also different.

As there is a maximum number of sessions, practitioners also wanted to save some for after the trial to be able to support the child post-trial and also because there was a sense that pre-trial sessions were not 'proper' therapy. Respondents reported that the timing of sessions could be difficult to manage, with most practitioners mentioning 'spacing sessions out', that is, maintaining a gap of two to three weeks between sessions in order to ensure the child could still access LTFI during and after the trial. Managing this was made more difficult as court dates are frequently cancelled and moved.

Yet other teams were more relaxed about cases in pre-trial status, which may be associated with more experience in working with them. One team had considerable experience working to support children affected by sexual abuse before the case came to trial because it had provided a witness support service before the introduction of LTFI. In consequence, they had a good relationship with the police and Crown Prosecution Service (CPS), and felt that pre-trial work was one of their strengths. Other teams with experience working with pre-trial cases also felt comfortable:

"We've always done it. I don't see what the problem is with LTFI and pre-trial, it's never been a problem." (Team manager, Team H)

Supervision

Practitioners were provided with managerial supervision, peer consultation, team meetings and in some cases clinical supervision, all of which provided some level of support.

Across the eight case study teams, five had had recent changes in management. Instability was a concern, as team managers played an important role in supporting and supervising practitioners. Managers and practitioners agreed that managerial case supervision was important in ensuring monitoring the progress of cases and keeping them 'on track'. However, there was less agreement on how competent managers were in providing guidance and reflection on the process of therapy with the children and in supporting practitioners to manage the emotional impact of the work. Most respondents felt that managers should have had experience of undertaking therapeutic practice themselves; three of the eight teams had a manager with such experience. In those teams, practitioners were more likely to report being happy with managerial supervision. In the other teams, managers reported that their own lack of therapeutic experience undermined them.

Practitioners were also offered support through a peer consultation model, where all practitioners in one team come together for a session facilitated by an experienced practitioner from a neighbouring team. These were planned to happen every six weeks. In year one, views on this model were very mixed. Several teams reported getting a 'poor deal', because it had been too difficult to arrange sessions. Some teams had arranged their own form of peer consultation with external experts. Practitioners also considered that peer consultation concentrated too much on organisational politics, or was badly facilitated. However, in year two we noticed a marked improvement in how peer consultation was perceived, with more practitioners seeing it as a good model of sharing practice and learning from peers. Practitioners commented on the benefits of reflecting on their work in a group setting, with proper space to explore both problems and successes. For example, one practitioner explained:

> "[In] peer consultation, we've taken it in turns to really look in depth at someone's case and I think you learn a lot from that both as the person whose case it is [i.e. if it is the practitioner's own case that is being discussed]: it gives you new ideas and makes you think, 'Oh no, I hadn't thought of that' or, 'Actually, this is a really difficult situation to be working with', and just have that ability to reflect on that…or you're hearing what someone else is doing with a child and you think, 'Actually I could do that'. You've always got children in mind that you could [think], 'I could try that with them'." (Practitioner, Team H)

All practitioners believed that clinical supervision was important, even those who had never had access to it. Most raised concerns about the lack of clinical supervision, believing that it would improve outcomes for children and young people. They thought that clinical supervision would offer the opportunity to speak about the personal impact of cases outside line management arrangements, where some issues were considered too uncomfortable or inappropriate to raise. These included feelings of frustration about cases, and the emotional impact on practitioners. Several practitioners paid for their own clinical supervision, both to support practice but also because this was a requirement for their professional registration as therapists. Team managers generally considered that their practitioners might benefit from clinical supervision, but that they were working very well without it.

Safe carer work

There remain issues with the timing of this work, both with regard to when the sessions with carers should commence in relation to the child's intervention, and holding carer sessions simultaneously with the child's sessions.

7.4 Discussion of the process evaluation

The adoption of new models of intervention presents a number of problems in real–world settings. For example, while evidence for a particular approach may be strong, programmes are not always implemented in the same way or with the same quality as when they were first proposed or evaluated (Greenberg et al, 2005). Some elements of a planned programme may be left out or overlooked. Practical difficulties may mean that aspects of a programme are not adhered to as rigorously as intended. Those implementing the intervention may lack the required training and professional skills to practice using the intervention. Alternatively, practitioners may be skillful and well trained, but disagree with a given approach and, therefore, may choose to practice in a way that is not reflective of the intervention. In such circumstances, adherence or fidelity to the model may be weak.

Despite the many and varied programmes and intervention models proposed for children and families in social work and related disciplines over the last two decades, studies of the process of implementing new interventions remain relatively rare. Greenberg and colleagues (2005) contend that "although the evidence base of… programs is quickly growing, the science regarding *how* programs are implemented under real–world conditions is poorly developed" (p.i–ii). They suggest that there is a very limited knowledge base on the measurement of implementation and on the relationship between

the quality of the implementation and the outcomes for children and young people.

In the current evaluation of LTFI, it has been important to address not only the impact of the intervention, but also the process by which the intervention has been adopted within teams and offered to service users. For example, if the intervention had not been offered as intended or had seriously diverged from the guidance, then any (positive or negative) outcomes reported in the impact evaluation could be reflective of the failure to adopt the intervention correctly, rather than as a result of the intervention itself. Therefore, the process evaluation sought to add to the findings of the impact evaluation by answering two specific research questions:

- How is LTFI delivered?
- What are children's, safe carers' and practitioners' experiences and perspectives of the intervention?

Dane and Schneider (1998) specify five aspects of implementation quality in their review: adherence, or the degree to which programme components are delivered as prescribed; exposure, of the frequency and duration of the programme delivered; content and affective quality; participant responsiveness; and programme differentiation (by which they refer to studies in which control groups are given alternative interventions to an intervention group and the importance, therefore, of distinguishing between the two interventions).

Using Dane and Schneider's categorisation, the strengths of the current study of the implementation of LTFI, therefore, includes the systematic collection of data throughout the study, which enabled the evaluators to monitor the degree to which the LTFI guide was *adhered to*. Interviews with team members as part of the team and family case studies allowed the exploration of how practitioners used the guide in practice, including the extent to which they adhered to the proposed structure and content. In terms of *exposure*, we collected data from well over 2,000 individual sessions using the Intervention Checklist, which enabled analysis of the frequency and total number of sessions on offer to children, young people and carers over a sustained period of time. The Intervention Checklist data also enabled an analysis of the *content* of the sessions on offer, including practitioners' choice of interventions. Thus, it has been possible to assess the extent to which practitioners self-report the use of the varying content as well as theory proposed in the guide.

The combination of quantitative and qualitative data here is a strength. A relative weakness of our approach, however, is reliance on practitioner self-report in both interviews and in relation to the Intervention Checklist. Without direct observation of the actual sessions offered to children and young people, which was both beyond the scope of the study and also would have been highly problematic ethically, we have no way of knowing how far practitioners' accounts of their use of the intervention was reflected in the reality of their practice. At the same time, the inclusion of service user feedback in relation to the TASC data, as well as qualitative interview data from the family case studies and therapeutic relationship study, have enabled users to comment directly on their experiences of the intervention and their relationships within therapy, addressing Dane and Schneider's fourth point on *participant responsiveness*. Finally, the relative weakness of the waiting list control design has meant that the LTFI intervention has not been compared here with the challenges and issues associated with offering a competing intervention (*programme differentiation*). However, a number of practitioners in the team case studies did reflect back to their experiences of working in NSPCC teams with children who had experienced sexual abuse prior to the adoption of LTFI.

Taking into account these strengths and limitations, the findings presented above do appear to indicate that LTFI has been delivered as intended by staff who appear appropriately trained and skilled to deliver the intervention as proposed. Indeed, data from our survey of 80 children's practitioners indicated that those delivering LTFI were a surprisingly highly experienced staff group, with 80% having been professionally qualified for over six years and with almost three quarters having at least six years' experience of undertaking direct work with children.

The extensive experiences of staff implementing the new intervention also emerged very strongly through the interviews with them in the team case studies. There was a clear sense of progression between the implementation issues described by practitioners in the first year of the team case studies and the second year, when many of the initial concerns and uncertainties had been addressed. It is, therefore, significant that the overwhelming majority of staff understood their roles, felt confident in their own abilities to offer the LTFI service and felt able to communicate with children about sensitive issues relating to sexual abuse. The confidence and competence of staff clearly supported the implementation of the new intervention model very well.

Likewise, it is clear that the LTFI model has been broadly acceptable to practitioners and managers involved in the delivery of the service. Those staff who had worked therapeutically with children affected by sexual abuse prior to the implementation of LTFI generally indicated that the model was consistent with their previous ways of working, though the limitations placed on the number of assessment and intervention sessions meant that they had to organise their work somewhat differently. However, practitioners appreciated the flexibility of the LTFI approach conceptually and theoretically, particularly the emphasis on child-focused and creative methods.

Data from interviews with team members, as well as that collected as part of the Intervention Checklist, suggests that LTFI has been delivered in accordance with the protocols and requirements of the guide. However, as identified in the findings section above, by far the most contested area associated with the implementation of the service was the role and nature of work with carers.

Although there were divergent opinions expressed, the majority of practitioners interviewed felt that the carer element of the intervention should be revised. This might include making it more extensive (more scope for more sessions with carers), allowing more flexibility around the timing of sessions (for example, for safe carer work to be offered earlier in the overall intervention) and reviewing the purpose of the sessions (for example, for the carer work to be regarded as a core therapy, rather than socio-educative work to enable carers to support their child through the therapeutic process).

Carers were often struggling with overlapping issues beyond the impact of their child's abuse, including wider difficulties in the family and, in some cases, their experience of child sexual abuse in their own childhood. At the same time, data from the Intervention Checklist has indicated that, in many cases, practitioners did not undertake any individual work with carers, and where they did, did not use all eight sessions suggested in the guide – in some cases because of difficulties they faced in engaging carers. Discussion with practitioners (through dissemination workshops) have also raised the question of whether engaging safe carers more fully in the work is particularly important in relation to younger children accessing LTFI. Conceptually this, of course, makes sense.

As young people progress through adolescence, one of the strongest development themes is increasing independence and separation from parents and carers. Conversely, younger children are generally more reliant on their family contexts and more likely to understand their own identities in relation to their carers as key attachment figures. This might suggest a more extensive involvement of carers is warranted with younger children, not least given the emphasis practitioners placed on self-esteem and self-identity work, as

highlighted in the findings from the Intervention Checklist. In other words, to undertake this work with young children, it may require more active engagement and more extensive involvement of carers. This is also one possible explanation for the less favourable results reported in the impact evaluation in relation to younger children.

Alternatively, it might also be the case that safe carer work may also impact on carers' capacity to accurately report the child's difficulties in the TSCYC. The major finding here, however, is a degree of confusion on the part of practitioners about the purpose of safe carer work within LTFI, which would benefit from clarification in the further development of the intervention.

In summary, the findings from the process evaluation suggest that, in the main, the structure of the intervention was consistent across teams and with the guide. In particular, practitioners used the assessment model described in the guide, liked and used the intervention components, and viewed cases that exceed the recommended number of sessions as exceptional. Practitioners took a flexible approach to the delivery model and were able to tailor their approach to suit the needs of the child. Most practitioners reported being very flexible and 'child centred' with the order in which the intervention components were covered in sessions.

Practitioners broadly welcomed the intervention components. Building a strong therapeutic alliance was seen as the most important factor in the success of the work with the child. We found some evidence of inconsistencies across teams in the following areas: confidence in working with pre-trial cases; perceptions of the value of safe carer work as described in the guide, in particular its aims, and the timing of the work. Practitioners would benefit from increased opportunities for training and professional development, and more consistent managerial support (in particular for reflecting on the therapeutic process, and dealing with the emotional impact of this work). This is particularly important in the absence of clinical supervision. There is evidence that the peer supervision model improved over the two case study years and is now valued by practitioners.

It is significant and notable that all practitioners involved in the qualitative element of the process evaluation were unanimous in their belief that the intervention is of benefit to children and young people affected by sexual abuse. This is also reflected in the views and experiences of those young people and carers who were interviewed, who have given a very positive account of children and young people's experience of LTFI, and attribute recovery from the effects of child sexual abuse to the intervention.

Children, young people, their safe carers and practitioners all report the development of strong therapeutic relationships between children and their workers, which was a critical element of the intervention. Although it is important to note that we were not able to access young people or carers who did not complete the intervention, and, therefore, the user voices and experiences reported here may not be representative of the whole range of those referred to the service, the strength of the positive experiences reported by service users, alongside the views of practitioners, is very encouraging.

8. Concluding comments

Letting the Future In was developed by NSPCC practitioners as an approach to therapeutic work with children affected by sexual abuse. With the help of input from a research review, it was formulated as a practice guide, and over the course of four years was implemented in twenty teams in England, Wales and Northern Ireland. It is very creditable that the NSPCC commissioned an independent external evaluation of the impact, process and costs of the programme and also that it accepted the research team's recommendation that the impact be evaluated using a randomised controlled trial (RCT). It is unusual for a service organisation to be quite so open to rigorous evaluation and to the risk that the results might show that the service is ineffective or even damaging.

The use of RCTs in social work research with children and families in the UK is quite rare. One reason is that there are many opponents on principle to this methodology and the other is that they are generally difficult and expensive to carry out (Jessiman et al, 2016). UK researchers have typically reported major problems in gaining senior management commitment and support, engaging the cooperation of practitioners, and have experienced serious difficulties in recruiting sufficient participants (for a recent example, see Dixon et al, 2014). In that context, this evaluation shows what can be achieved: not only was it successful in gaining commitment, but it also exceeded expectations in recruiting children and their carers, making it the largest RCT of a therapeutic intervention for child sexual abuse to have been conducted anywhere in the world. It is also one of the largest case-randomised (as opposed to a cluster-randomised) controlled trials of a social work intervention outside the USA. This was achieved through a robust partnership between core NSPCC staff responsible for the design and delivery of the programme at national and team level, and the joint universities' research team. We have discussed how the research design and procedures for the trial were worked out, including managing the risks of using a waiting list control group (Jessiman et al, 2016).

The evaluation is unusual in research on child sexual abuse in employing mixed quantitative and qualitative research methods. Almost all other studies have relied on the use of quantitative outcome measures alone. The current study has successfully collected qualitative data in the form of team cases which have described in detail practitioners' and managers' experiences of implementing the intervention. Such studies of the implementation of therapy are rare and the findings here will be of importance to others who may wish to introduce new models of practice and therapeutic work with children in the future. Most significantly, the views and experiences of carers and, especially, children have very rarely been heard in previous outcome research.

Finally, the last component of the evaluation, the economic evaluation, had reached the analysis stage and will be published separately. This too will break new ground in that it appears to be the first evaluation of a sexual abuse intervention to have collected prospective data on the child and main carer's use of a range of health and social care services in order to estimate costs and cost-effectiveness.

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