Responding to Child Victims and Witnesses of Trauma and Abuse:
Addressing the Support Needs of Children and Families
Through the Barnahus Model

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Summary and Recommendations

Violence against children, defined as 0-18 years of age, is a significant global concern with potentially far-reaching and costly consequences to the child and to society. For children and families who have been affected by violence, having an effective process of protection and recovery that helps to bring justice, closure, and reintegration in society is a key need. The United Nations Convention on the Rights of the Child (1989) is an international treaty for children’s rights, for example the right to be safe from all forms of violence, the right to be active participants in the decision-making processes that involve them, the right to be heard and valued, and the right to recovery after any violence has occurred. The Council of Europe Convention on Protection of Children Against Sexual Exploitation and Sexual Abuse (2007), or “Lanzarote Convention” indicates that member states, including the United Kingdom, should provide a coordinated multiagency response when walking through the disclosure journey (justice and recovery) with children and families. The Barnahus model builds upon the Child Advocacy Centre model (Herbert et al., 2018) to fully uphold child rights standards as outlined by the UNCRC, as well as the international standards as outlined in the Lanzarote Convention, and is supported by the Council of Europe (2018).

The European PROMISE network outlines the core standards that should be included in any Barnahus model (Haldorsson, 2017), and are discussed in detail in this report. Briefly, they are (1) in accordance with child rights standards of participation, access, and no undue delays to recovery and justice; (2) having a multiagency and multidisciplinary team; (3) a broad mandate for eligibility; (4) a child-friendly environment; (5) efficient case management across agencies; (6) a child-friendly forensic interview; (7) a child-friendly medical examination; (8) a child-friendly therapeutic service; (9) capacity building for professionals; and (10) building community prevention awareness and knowledge mobilisation through Barnahus. These core standards are premised on the idea that Barnahus is a “one-stop-shop” location where all of the above services are co-located to provide continuity of service across agencies, ease of access for children and families, and to ensure a high standard of service that is tailored to the child’s specific needs as well as non-offending family members.

In sum, the Barnahus model is fundamentally premised on colocation of services that are interwoven and mutually informed and that are tailored to the specific needs of children and their non-offending family members in such a way as to reduce trauma and speed the recovery of children and their families after experiencing or witnessing abuse and violence. The Barnahus model is associated with better judicial and support outcomes, and at the same time, the model supports and upholds international standards of children’s rights to participation, access of information, and reducing undue delays while reducing the trauma experienced by children and their family members during the disclosure journey and support process.

Key Recommendations

These recommendations stem from the Council of Europe (2018) recommendations for Barnahus as well as from best-practices in the research and policy literature.
1) Recommend that a “one-stop-shop” model of Barnahus, in which all procedures and services relating to justice and recovery (i.e., forensic interview including pre-recorded trial evidence, medical examination, therapeutic services and ongoing support) are provided under one roof in one location for children and their non-offending family members.

2) Propose that the use of Barnahus, as a multidisciplinary multi agency response model for children who have experienced or witnessed forms of violence, be formally incorporated into legislation to ensure equity of access for children across Scotland to the service.

3) Propose that the eligibility criteria be as broad as possible to include children who have experienced or witnessed all forms of violence (physical abuse, sexual abuse, neglect, sexual exploitation, domestic violence).

4) Recommend that any alleged adult offender receive services through another venue than the Barnahus.

5) Consider joint responsibility for Barnahus between Health and Justice sectors.

6) Propose that routine monitoring and evaluation of service provision should be part of organisational planning and budgets. Evaluation should be informed by multidisciplinary team members and the children and families who use the service. It is recommended that similar data and information is gathered across Barnahus sites to support a longer term national evaluation of services and service improvement.

7) Recommend that equitable access to service to all children is ensured, so as not to exclude children with disabilities, children of varying races and cultures, and children living in rural and remote communities.

8) Ensure that a systematic case management system is in place for multi-agency collaboration.

9) Recommend that children and their families be viewed as key stakeholders and that they be part of the development of all Barnahus decisions as active coproducers of the model and response.

10) Recommend that all forensic interviews be conducted by a specialist trained child forensic interviewer (e.g., child psychologist, child forensic interviewer) who has knowledge and experience using evidence-based interviewing protocols with children.

11) Forensic interviews are recorded to very high audio-visual specifications. The child’s face should be easily visible and voice should be audible so that recordings can be used in any court proceeding. Transcripts of the interview are not recommended in lieu of the recording for use in judicial proceedings.

12) Recommend that all non-acute forensic medical evaluations be conducted onsite in a child-friendly medical examination room at the Barnahus by a specialist doctor with experience of identifying indicators of violence and abuse against children (physical abuse, sexual abuse or exploitation, neglect).
13) Recommend that the child and non-offending family be actively involved in all aspects of the Barnahus (i.e., child and family can decline services or procedures, are involved in decision-making about the case, etc).

14) Recommend that a child advocate or similar be assigned to the child and family from the beginning of the process to the end of case completion. This advocate or similar position should follow the child and family through the process and be available as a first point of contact to provide information about any procedures within Barnahus (e.g., forensic interview, evidence-gathering).

15) Recommend that on-going therapeutic support be offered to the child and family, or be available to the family, for an extended follow-up period of time beyond case completion to avoid the child and family returning to the criminal justice/social service and health care system due to unresolved trauma or negative impacts.

16) Ensure that the child’s pathway in and out of Barnahus is integrated into current Scottish Child Planning processes and guidelines. Embedding Barnahus within the Getting it Right for Every Child planning processes will ensure children and families receive appropriate supports from education, voluntary sector, health and social services. Thus, children who are being seen at Barnahus have the means for any services to be adapted for their needs while they have an open case with Barnahus and an informed plan of action for the child once the child’s case is closed with Barnahus.
Abstract

In this report, we (1) present the scope of violence against children, including during the COVID-19 pandemic, (2) discuss the impact of experiencing and witnessing forms of violence as a child as well as the support needs of children and families during recovery from forms of violence, (3) present child rights and international standards relevant for recovery-based models, (4) discuss core standards for the Barnahus recovery model, situated within the research and policy evidence base, and (5) present recommendations for developing standards for a Barnahus recovery model in Scotland. This report was commissioned by Healthcare Improvement Scotland.
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Responding to Child Victims and Witnesses of Trauma and Abuse:

Addressing the Support Needs of Children and Families through the Barnahus Model

Violence against children, defined as 0-18 years of age, is a significant global concern with potentially far-reaching and costly consequences to the child and to society. For children and families who have been affected by violence, having a process of protection and recovery that helps to bring justice, closure, and reintegration in society is a key need. The United Nations Convention on the Rights of the Child (1989) is an international treaty for children’s rights, for example the right to be safe from all forms of violence, the right to be active participants in the decision-making processes that involve them, the right to be heard and valued, and the right to recovery after any violence has occurred. The Council of Europe Convention on Protection of Children Against Sexual Exploitation and Sexual Abuse (2007), or “Lanzarote Convention” indicates that member states, including the United Kingdom, should provide a coordinated multiagency response when walking through the disclosure journey (justice and recovery) with children and families. The Barnahus recovery model builds upon the Child Advocacy Centre model (Herbert et al., 2018) to fully uphold child rights standards as outlined by the UNCRC as well as the international standards as outlined in the Lanzarote Convention, and supported by the Council of Europe (2018).

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Violence Against Children and the COVID-19 Pandemic

A systematic review of past-year violence against children (i.e., emotional, physical, sexual, multiple types) estimated that more than a billion children all over the world have been exposed to violence (Hillis et al., 2016). In terms of changes during the COVID-19 pandemic, global and country-level estimates have been very limited mainly due to ethical and methodological challenges of collecting sensitive data from children during any forms of lockdown, yet, preliminary studies suggest that the COVID-19 pandemic is likely to exacerbate children’s exposure to violence at home (Fabbri et al., 2021; Ritz et al., 2020). Factors such as economic instability, extended school closures and lockdown measures, and increased caregiver stress levels are among some of the potential pathways to violence (Bhatia et al., 2020).

In Scotland, data from the Scottish Government (2020) suggest that for some children living in homes where there was abuse or violence (including domestic violence), that the increased time at home meant more time was spent being exposed to violence. Additionally, support services reported that perpetrators purposefully distorted lockdown measures in order to further manipulate and isolate children (Scottish Government, 2020). Data from Police Scotland...
(2020) indicate a 7.6% increase of domestic abuse police reports from 2019 to 2020 and a further increase of 3.6% in 2021 compared to the year prior. Domestic abuse crimes recorded are 6.0% higher compared to the five-year mean. Police Scotland (2021) also report an upward trend of online child sexual abuse and exploitation with an increase of 13.4% in 2020 compared to 2019 which is 33.9% higher compared to the five-year mean. Further, according to the United Nations Leader’s Statement on Violence Against Children, the measures that are needed during COVID-19 to contain the virus are also exposing some children (i.e., those to whom there is violence occurring at home) to a higher risk of experiencing violence due to school closures, service reductions, and additional strains on caregivers (Fore, 2020).

**Impact of Experiencing and Witnessing Trauma and Abuse on Children and Families**

Exposure to abuse during childhood, especially without adequate support and recovery, can have consequences on lifelong health and well-being (Leeb et al., 2011). For instance, experiencing forms of abuse during childhood has been linked to poorer mental (e.g., depression, suicidality) and physical health outcomes (e.g., obesity, chronic diseases) and even premature mortality (Angelakis et al., 2019; Brown et al., 2009; Brown et al., 2010; Thomas et al., 2008). Without proper support and recovery, future generations can also be affected by a former generation’s experiences of childhood abuse. For example parental exposure to childhood abuse has been linked to decreased empathy (Bert et al., 2009) and insecure parent-child attachment relationships, which may then lead to internalising and externalising problems in early childhood (Cooke et al., 2019). Further, a recent meta-analytic review by Madigan and colleagues (2019) of 142 studies on the intergenerational transmission of violence found that there is a modest effect for intergenerational violence. That is, the authors found a statistical association between having experienced abuse as a child and then committing acts of abuse as a parent. The message from the findings of this meta-analysis is that it is important to consider how to help children and families who have experienced abuse to build resilience and recovery because the effects of experiencing childhood abuse are not likely to just “go away on their own” without support and recovery. Further, a prolonged investigative and judicial process can exacerbate and add further layers of trauma to children’s experiences (Ryan et al., 2006). However, **there is strong evidence that children receiving evidence-based help as soon as possible after any maltreatment will make a quicker recovery, and these improvements are more likely to be sustained** (NICE, 2017).

Despite the very real and harmful effects of experiencing abuse during childhood, it is important to highlight that **children, as well as adults, are by nature resilient**. Resilience is the dynamic process of positive adaptation in the face of significant adversity (Cichetti, 2013). Although child maltreatment literature predominantly focuses on investigating the adverse health consequences of violence exposure to ensure that adequate attention is given to ending violence against children, there is strong field of evidence that focuses on how **children and adults adapt to challenges through their own self-efficacy and with the assistance of external relationships, systems, and processes to overcome adversity and even become stronger in spite of having experienced adversity** (Masten & Barnes, 2018). Individuals who have experienced cumulative and severe childhood adversities are able to function positively at home and in society, be compassionate and show empathy towards others, as well as have
Positive health behaviours, and this is enhanced by being in community and having the support of others around them (Brown et al., 2021; Hemady et al., 2021; Lavoie et al., 2016; Masten & Barnes, 2018).

Physical and Mental Health Needs of Children and Families After Trauma and Abuse

Children and their families have particular needs to keep in mind during the disclosure journey and recovery process. Ryan and colleagues (2006) emphasise the importance of a committed and supportive multi-disciplinary team (MDT) with work grounded on trauma-informed practice. To this point, they argue that in order to fully address the needs of abused children and their families and mitigate system-generated trauma, an extensive trauma history must be completed and shared with the team. Not only will this be beneficial for the child’s health, it may have a positive influence on the judicial process; for example, being cognizant of the child’s trauma triggers and reminders, MDT members can undertake practices that may minimise the child’s fear or anxiety during forensic interviews, which in turn may reduce the number or length of interviews needed.

Children who have experienced abuse may be placed in temporary care settings, which in turn may also separate them from friends and families for long durations. Ryan and colleagues (2006) emphasise the importance of providing a sense of continuity (by tying the past and present together), by keeping them in touch with their supportive network. For example, therapeutic group work with children and parents affected by domestic violence provide opportunities for relational repair and may also be a way for children to understand and process what they have experienced (Bunston et al., 2016).

When designing therapeutic interventions for children who have experienced abuse or domestic violence, it can be helpful to be aware of the specific types of programs that may help to address their needs (NICE, 2017). For example, children who have experienced abuse or who have been exposed to domestic violence may have a higher likelihood of developing internalising/externalising behaviour problems, post-traumatic stress disorder (PTSD), and a broad range of adverse psychosocial outcomes. In response, programmes that focus on fostering emotion regulation and interpersonal skills, and developing positive coping mechanisms and resilience strategies have been found to have favourable effects (Callaghan et al., 2019; Lacasa et al., 2018). In addition, programmes that build positive parenting attitudes and emotional growth decrease the stress levels of the non-abuse caregiver after treatment (Carter et al., 2003), which also has a positive impact on the child and the home environment. Finally, cognitive-behavioural treatment is associated with increased self-esteem, fewer PTSD symptoms and fewer adaptation of maladaptive coping strategies among child sexual abuse victims in particular (Hubel et al., 2014), and is well-supported by the literature as an effective therapeutic intervention (Hofmann et al., 2012; NICE, 2018).

Support Needs of Children and Families During Disclosure Journey

Although there is much discussion within the field of research on children’s disclosures of abuse (discussion available in forthcoming 2021 White Paper on Child Forensic Interviewing by the European Association for Psychology & Law), there is agreement that (1) children do not always
initiate a disclosure on their own (e.g., Rush et al., 2017), (2) children do not always disclose their experiences of abuse, even when questioned directly (e.g., Azzopardi et al., 2019), and (3) children’s experiences of abuse tend to lend themselves to a certain level of reluctance to disclose to authorities (e.g., Hershkowitz, 2006; Lavoie et al., 2019). There are specific aspects of children’s own development as well as circumstantial factors that can impact how they disclose and whether, or how, reluctant they are to disclose to authorities.

For example, children’s age is one of the key developmental aspects that is associated with disclosure tendencies (Hershkowitz et al., 2007; Hershkowitz et al., 2012). One relevant study, which was notable due to the use of advanced statistical methodology, relative to other studies in the field that have assessed quadratic relations rather than only linear relations, found that age 11 is a peak age for disclosure willingness, with disclosure likelihood increasing from age 3 until age 11, and then decreasing from age 11 to age 16 (Leach et al., 2017). Age is associated with children’s disclosure tendencies as it may reflect language abilities, for example narrative sequencing skills, which are important for disclosures (Miragoli et al., 2017). Children are also more likely to be aware of what constitutes abuse, specifically neglect, with age (Lavoie et al., 2019b) and they are also more likely to be aware of the impact and consequences for disclosures (Malloy et al., 2007; Malloy et al., 2011). Overall, this information can help to situate children’s experiences within recovery-based models because it lends context on how they might “arrive” at a Barnahus or other recovery-based service.

Protected Characteristics, Child Rights, and International Standards

Protected Characteristics Based on the Equality Act (2010)

The Equality Act 2010 (Equality and Human Rights Commission, 2010) aims to protect individuals from discrimination in the workplace and in society and includes nine specific characteristics that should be taken into account when working with individuals to reduce discrimination. For children and families in particular, previous research and policy provide additional information about what this looks like in practice, and we outline this specifically for age, disability, race, and sex in more detail below, and have added socioeconomic status and geographical location as well.

Age

Age is a significant factor in how violence is experienced and is an important factor in designing recovery services to support children. A recent report by the National Society for the Prevention of Cruelty to Children (NSPCC) demonstrated that police-recorded crime rates against adolescents were substantially higher compared to crime rates against younger children. Specifically, adolescents were four times as likely to report physical abuse offences, six times as likely to report sexual offences, and nine times as likely to report online sexual violence offences (Bentley et al., 2020). Violence exposure at any stage is harmful and should be critically addressed, however, research suggests that the developmental phase when trauma or violence was experienced is a significant factor to later life outcomes. A study by Dunn and colleagues (2013) found that maltreatment exposure during early childhood, particularly between 3-5 years old, increased likelihood of depression symptoms and suicidal ideation in
young adulthood compared to exposure during adolescence. Similarly, a UK-based study reported that exposure to abuse during childhood (<11 years old) was associated with increased risk of conduct problems compared to exposure during adolescence (Bauer et al., 2021). Older children who have experienced adversity are at an increased risk of dying by suicide (Devaney et al., 2012). The child’s age is also associated with developmental maturity (e.g., cognitive ability, language skills, psychosocial maturity), and children will have different abilities and needs in association with their age and corresponding developmental maturity. This is particularly important to acknowledge in the child’s disclosure journey and during the recovery process.

Disability

Children with disabilities are significantly more vulnerable to abuse exposure than children without disabilities (Frederick et al., 2019), and are more likely to experience multiple forms of abuse (Stalker & McArthur, 2012). Children with communication difficulties, behavioural problems, and learning disabilities are more at risk of physical abuse while children who are deaf have increased risk of sexual abuse (Stalker & McArthur, 2012). Children with disabilities who have experienced abuse may experience further isolation which can contribute to the abuse remaining unnoticed (Stalker et al., 2015). Further, incidences of abuse towards children with disabilities remain severely underreported and unidentified and are therefore not reflected in the system (Stalker & McArthur, 2012). In Scotland in particular, the number of children with disabilities on child protection registers remain low (Stalker et al, 2015). Where incidences of abuse towards children with disabilities are suspected, referral to appropriate services may still not be provided or may be accorded low priority (ibid). Stalker and colleagues (2015) emphasise the importance of placing the child at the centre of practice. This may entail specialised training for staff undertaking work with children with disabilities to heighten understanding of different forms of disabilities to tailor support according to the child’s needs. It is also crucial to develop safe reflective spaces where children with disabilities can be actively involved in evaluating and informing child protection systems and practices (Taylor et al., 2014).

Children with cognitive and language delays or disabilities in particular also have additional needs to be considered for the forensic interview. Given that these children are over-represented in populations of children who have experienced abuse (Hendricks et al., 2014), it is important to consider how to best communicate with children with cognitive and language disabilities during the forensic interview in particular to help children have the opportunity to share their experiences in such a way that will be considered a strong witness statement by the judicial system. It is also important that children with specific developmental needs not feel as though they are being overlooked in their disclosure journey or in their experiences with the legal and social service systems (Stalker et al., 2015). Further, professionals interviewing children with specific developmental needs (e.g., cognitive delays, language considerations, developmental delays) often communicate feeling under-equipped to interview children with specific developmental needs (Shannon & Agorastou, 2006; Taylor et al, 2016), and this can result in a tendency for interviews with children with specific developmental needs to have a higher reliance on more direct and suggestive questioning (Brown et al., 2017; Cederborg &
Lamb, 2008), which is not in line with best-practice recommendations for child forensic interview (e.g., Blasbalg et al., 2020; Lavoie et al., 2021).

**Race**

Race is associated with children’s likelihood of being involved in the child protection system. This association is complex, as race and ethnicity intersect with other structural issues experienced by minority populations, such as higher rates of poverty, and, at the same time, greater levels of surveillance and intervention compared to majority populations (Bernard and Harris, 2016). It is also possible that children from minority ethnic backgrounds may be differently impacted by the maltreatment they experience. For example, a US-based study found that African American men and women exposed to abuse in childhood were more likely to have depressive symptoms, in comparison to White and Hispanic counterparts (Roxburgh & MacArthur, 2014). Alternatively, a study by Mennen (1995) involving 134 girls who had experienced sexual abuse found that race/ethnicity was not linked to the severity of depression, anxiety, and low self-worth indicators and symptoms. More locally, a report by the Independent Inquiry on the topic of child sexual abuse involving ethnic minorities suggests that exposure to sexual abuse during childhood led to feelings of shame, stigma, loss of self-identity and belongingness to their communities (Rodger et al., 2020). Institutional racism, cultural stereotypes and assumptions of child protection practitioners, and cultural norms such as the code of silence were identified as barriers for disclosure and self-recovery (ibid). Race is fundamental to how children experience and view the world and should be considered throughout the disclosure journey and recovery process. Professionals can be sensitive to how services are delivered in ways which promote an inclusive and culturally appropriate service (Herbert and Bromfield, 2016).

**Sex**

Research findings suggest that women have a higher likelihood of experiencing violence or abuse, and that men have a higher likelihood of having adverse mental health problems such as depression (Roxburgh & MacArthur, 2014). On the other hand, Thompson and colleagues (2004) found that men were more likely to report exposure to physical abuse during childhood, yet, the adverse effects were more detrimental for women. As such, there is a clear need to focus on the delivery of services which are gender sensitive to both the experiences of different forms of maltreatment, and the immediate and longer term consequences.

**Socioeconomic status**

Household economic and social status are key determinants of health inequalities. To this point, research suggest a strong inverse association between families’ socio-economic circumstances and the likelihood that their children will experience child maltreatment. Evidence of this association is found repeatedly across economically developed countries, types of abuse, definitions, measures and research approaches, and in different child protection systems (Bywaters et al., 2016). Children from lower socioeconomic positions are more likely to experience physical abuse or neglect (Cawson et al., 2000), to be in foster and residential care (Bywaters & the Child Welfare Inequalities Project Team, 2020), to experience multiple and
more severe forms of childhood maltreatment (Lee et al., 2017), and to have a higher likelihood of physical health problems in adulthood (i.e., immunological and cardiovascular problems) and economic circumstances in adulthood (Bywaters et al., 2016). In the UK, a recent report by Bywaters & the CWIP Team (2020) suggest that structural inequities persist at the family level, local area level, and even at the national level, and that there is more to be done across research, policy, and practice to ensure that children and families have equitable access to resources and opportunities.

**Rural and remote area classification**

An evaluation study involving multi-disciplinary team members reported that urban bias or the inaccessibility of services to users in rural and remote areas is a serious challenge for quality service provision (Muridzo & Chikadzi, 2020). One possibility for addressing the needs of children and families in remote services is through a remote service mobile response team (Herbert & Bromfield, 2017), as the travel required for a child and family to travel into a main location can be a substantial barrier for accessing justice and recovery responses needed to support the child and family.

Further to the above stated protected characteristics, based on the principles of the Equality Act 2010, no discrimination should be experienced by children or families on the basis of gender reassignment, marriage and civil partnership, pregnancy and maternity, religion or belief, or sexual orientation.

**UNCRC Principles for Recovery**

The United Nations Convention on the Rights of the Child (UN General Assembly, 1989) outlines the standard of human rights that children, up to the age of 18, should be privy to in their daily lives and throughout their upbringing. Broadly, they cover children’s rights to be safe, heard, valued, educated, and be active participants (i.e., have decision-making power as appropriate) in their lives. In particular, children have a right to be raised in safe environments free from all forms of abuse, neglect, and violence (Articles 19, 34, and 35). Of relevance for recovery-based models, including the Barnahus model, are the articles that discuss the best interests of the child (Article 3), the child’s right to participation (Article 12), the child’s right to freedom of expression (Article 13), and the child’s right to recovery (Article 39).

**Best Interests of the Child**

“In all decisions and actions that concern children, the best interests of the child shall be a primary consideration” (UNCRC, Article 3)

The best interests of the child captures the principle that decisions made about children’s lives should be helpful for their development and should take their holistic needs into account at each of point in decision-making and actions. Further, the best interests of the child also reflects the need to be aware of and to focus on the individual needs that a child will have, and to adapt the process and decision-making to that particular child.

**Right to Participation**
“Every child has the right to express their views on matters that affect them, and for these views to be taken into consideration” (UNCRC, Article 12)

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Children have a right to express views on all matters affecting them, and to have them given due weight. This is commonly described as “child participation”, embodied in Article 12 of the CRC, and applies to all children capable of forming a view. Children have the right to express their views freely in all matters affecting them and these views will be given due weight in accordance with their age and maturity, and that the child should be provided with the opportunity to be heard in any judicial and administrative proceedings affecting the child. In sum this means that any children who are involved with a Barnahus have the right to express their views and have them given due weight at an individual and collective level. Children’s participation should be tailored to be appropriate for their age, developmental needs, and their desires to be involved in decision-making processes.

Right to Freedom of Expression

“Every child must be free to express their thoughts and opinions and to access all kinds of information, as long as it is within the law” (UNCRC, Article 13)

Children should be free to express their views within the scope of the law. Of relevance for recovery-based models, children should be able to access all kinds of information, both to inform their views, but also related to their own care and judicial case, as is relevant for their ability to form an opinion and express it.

Right to Recovery

“States should do all they can to help any child who has been neglected, exploited, abused, tortured or involved in armed conflict to recover their health, self-respect and dignity, and to reintegrate” (UNCRC, Article 39)

Children have a right to recovery after they have experienced any type of trauma or abuse, and this recovery should be holistic, focused on the child’s specific needs and best interests, and should include a plan for helping children reintegrate fully into society (e.g., ensuring they have educational and other support needs met) as part of their recovery.

Lanzarote Convention

International conventions, for example through the Lanzarote Convention, support that member States should “ensure the coordination on a national or local level between the different agencies in charge of the protection from, the prevention of and the fight against sexual exploitation and sexual abuse of children, notably the education sector, the health sector, the social services and the law-enforcement and judicial authorities.” (Article 10.1). This international standard is fully met through the Barnahus model (Council of Europe, 2018), as discussed below.
Part of the importance of the international legal standards is ensuring no undue delay. As the case of MacLennan v HM Advocate showed in 2015, a delay of a year between the Joint Investigative Interview and cross-examination taken on commission meant that the memories of the young children giving evidence had deteriorated to such an extent that the cross-examination was found to be ineffective and the trial was deemed unfair.

**Vulnerable Witnesses Act (2004)**

The Vulnerable Witnesses Act (2004) provides measures for providing additional flexibility for child witnesses in the court system, such as by allowing children to provide testimony via a live link from a list of permitted remote sites (i.e., not in the court room with the defendant). The child is also permitted to have a support person and an interpreter if needed. The **Victims and Witnesses (Scotland) Act 2014** introduced a number of measures to improve support for victims and witnesses including making it easier for vulnerable witnesses to give evidence in criminal trials by increasing the use of pre-recorded evidence. The Vulnerable Witnesses (Criminal Evidence) (Scotland) Act 2019 says child witnesses under 18 are allowed in the most serious cases to have evidence pre-recorded in advance of the trial.

**Recovery-Based Models for Children and Families**

There are several forms of recovery-based integrated practice models within the UK as well as globally. The “Barnahus” or “Child house” model originated in Iceland, partly developed from the Children’s Advocacy Centre model in the United States (Herbert, et al., 2018), and core to the model is interagency coordination between children’s health services (physical and mental health), law enforcement, social services and the judicial agencies.

There is an increased interest in the UK and Ireland in the Barnahus model. For example, Onehouse Galway is a pilot Barnahus in Ireland, The Lighthouse in London, England is a variation of a Barnahus model, and Scotland is in the process of implementing its own Barnahus model. Sir John Gillen’s review into the law and procedures relating to serious offences in Northern Ireland recommended that the Barnahus model be given serious consideration.

Across Europe, Barnahus has been championed as a child-friendly justice model and as a best-practice model that is aligned with international children’s rights standards (Haldorsson, 2017; Johansson & Stefansen, 2020) and that it can come alongside children and families following experiences of trauma or abuse. It is being implemented in 22 countries across Europe. Given the variations in how a recovery-based integrated practice model is implemented across the UK and even globally, it is important to assess key standards within a successful recovery-based integrated practice model that are effective at supporting the needs of children and families following an experience of trauma or abuse.

**Barnahus Core Standards**

To support the establishment of Barnahus models across Europe in compliance with European and international law, the PROMISE network developed the **European Barnahus Quality Standards**, 10 in total. The main principles are:
- Respect for the participatory rights of the child by ensuring that the child is heard and receives adequate information and support to exercise these rights
- Multi-disciplinary and interagency collaboration during investigations, procedures, diagnostic and needs assessments and service delivery, to avoid retraumatisation and securing outcomes that are in the best interests of the child
- Comprehensive and accessible services that meet the individual and complex needs of the child and their non-offending family or caregiver
- Ensuring high professional standards, training and adequate resources for staff working with child witnesses and victims of violence.

Below, we briefly list and describe each of the 10 core standards that all Barnahus models should include and incorporate to be considered a Barnahus (Haldorsson, 2017). We have also integrated the literature basis for support for each core standard, highlighting how each standard is evidence-based.

1- Overarching Principles of Participation, Access, and No Undue Delays: Children and their families are key agents who shape the process of participation in Barnahus. They should have access to appropriate information about the process, they are able to influence the timing of the process, and there is care taken that no undue delays to any part of the process (including judicial) are experienced.

Children’s best interest must always be at the heart of practice. In line with Article 12 of the CRC, children have the right to be heard and they must be recognised as active agents in all matters that affect them, providing due weight to their views in line with their age and maturity (UN General Assembly, 1989). A key responsibility of Barnahus is to ensure that children and their families are afforded accessible and transparent information, allowing them to make informed decisions throughout the process. To this point, children and their families report that a positive aspect of court proceedings is when children are engaged as active participants rather than passive recipients of the process (Randell et al., 2018). Alternatively, delays and postponements of court proceedings is a main source of distress and anxiety for children and their families, and this is further exacerbated when MDT members are insensitive to their needs. For instance, failure to notify a child and their family about court date appearances is not only inefficient and a cause for undue delay, it also leaves children vulnerable to further traumatisation (Townsend et al., 2014).

2 - A Multi-Agency and Multi-Disciplinary Team that is recognised and monitored nationally as a recovery-based service, and is established as such by way of legislation or formal agreement.

Barnahus should be formally embedded in national legislation, certified and monitored by an accreditation body like the National Children’s Alliance (NCA), and recognised by national and local institutions working within the child protection system (Haldorsson, 2017). Further, the CRC states that professionals providing assistance to children and families exposed to violence should be trained and should closely follow protocols related to multi-sectoral collaboration (CRC General Comment no 13, par 50, 2011). Reviews that explored a multi-disciplinary team
response effectiveness (Herbert & Bromfield, 2019) and evaluated outcomes of recovery-based integrated practice models (Herbert & Bromfield, 2015; Westphaln et al., 2021) indicate that, in general, child abuse cases undertaken by multidisciplinary teams were more strongly associated with positive judicial outcomes (e.g., higher conviction rates) and increased receipt of health and support services compared to more traditional services. However, further research that identifies child health and family outcomes and mechanisms associated with multidisciplinary effectiveness is warranted.

3 - Broad Mandate for Eligibility: Children who have witnessed or experienced any form of violence should be offered services through Barnahus. In particular, Article 2 of the CRC stresses that all children have the right to protection from all forms of violence without discrimination (CRC General Comment no. 13, par 60, 2011). Barnahus can assume an integral role by ensuring that the obligation of the State in providing adequate measures is met by providing equitable access and support to all children and families who are referred to the service (Haldorsson, 2019).

4 - Child-Friendly Environment: The environment, including the waiting room, interview room, and medical examination room, should be child-friendly. The child should not come into contact with any alleged offenders, and the Barnahus services should be accessible (i.e., not discriminatory based on place of residence or additional accessibility needs). We break this down into further specifics below.

Accessibility of location

Barnahus should be situated in a location accessible to public transport and constructed with an inclusive design so that it is accessible and accommodating to all children and families, regardless of age, gender, disability, cultural background, or socioeconomic position.

Interior environment

The interior environment should be age-appropriate and exude an atmosphere of warmth and safety. Children and families who have utilised Barnahus services in Sweden report that a good environment is where staff are positive, kind, and receptive to their needs, this includes the provision of accessible and adequate information on the services offered by Barnahus, details of the investigative and legal process, and the roles and responsibilities of the Barnahus multidisciplinary team (Rasmusson, 2011). It is also Barnahus’ role to ensure that children and accompanying parents are provided with access to support tailored to their individual needs.

To ensure the safety and privacy of the children and non-offending parents, separate and sound-proofed waiting rooms should be available. An observation room where the MDT members can view and record interviews should be connected to the interview room through the use of dual mirrors. In this way the number of interviews and number of people conducting the interviews can be minimised (Haldorsson, 2017). The interview room should be comfortable and child-friendly and minimally furnished to avoid distractions. Interviews conducted in law enforcement agencies and child protection services may invoke fear from children and families.
because they associate this setting with having committed a crime or the removal of their children from their care, respectively (Cross et al., 2007).

Additionally, staff should ensure that the child and the alleged perpetrator would not come into contact with one another at any point, and ways to facilitate this could be by having separate entrances and areas or by scheduling their appointments (Haldorsson, 2017).

5 - **Interagency Case Management System:** There should be an agreed system in place that protects the child’s confidential information, but also reduces the need for the child and family to provide the same information to different agencies during the recovery-based process.

Barnahus should have a protocol on data protection and privacy with particular focus on interagency coordination which fit within legislation requirements. Additionally, staff must have ongoing training on procedures and best practices (Haldorsson, 2017). Specifically, a systematic and efficient case management system that would allow secure information to be exchanged between various agencies and sectors must be in place. This will enable as a resource conservation strategy and as a protective measure to ensure that children are not further traumatised by undue delay and prolonged investigative processes. Research findings suggest that the data source and quality of data is a potential source of bias to both research and service provision; inconsistencies in terminologies of abuse, negligent data entry, and the use of outdated case management systems can result in unreliable data being collected (Glassner, 2011; Ruggieri, 2005; Shepler, 2010).

6 - **Child-Friendly Forensic Interview:** The interview is conducted by a trained specialist professional, the interview is carried out according to best-practice protocols, and the interview is adapted to the child’s individual needs (e.g., cognitive delay, language considerations, cultural considerations). We further breakdown these components below and embed them in best-practice literature.

**Evidence-based practice and protocols**

The primary motivation of forensic interviews must be to elicit valid accounts from child witnesses without exacerbating trauma (Haldorsson, 2017; Lamb et al., 2007). Both factors are interrelated such that a largely positive experience during this process are more likely to lead to more detailed and credible responses and tolerance for questioning at a later stage (Davidson et al., 2006). Awareness of trauma triggers and reminders gathered through a comprehensive trauma assessment and adherence to evidence-based practice and protocols are ways to avoid retraumatisation and increase interview productivity (Haldorsson, 2017; Ryan et al., 2007). To this point, Price and colleagues (2016) found that the use of the National Institute of Child Health and Human Development interview protocol enhanced children’s comfort and productivity more than the interview guidelines from the Memorandum of Good Practice. The revised NICHD (Hershkowitz et al., 2014; Blasbalg et al., 2021) is also championed by the European Association for Psychology & Law as a best-practice protocol that is responsive to children’s needs (forthcoming in a 2021 White Paper on interviewing child witnesses).

**Specialist professional**
The UNCRC General Comment no. 13 (par 51; 2011) states that investigations of instances of violence must be conducted by a qualified professional who has undertaken specialised and comprehensive training and is informed and must observe a rights-based and child-sensitive approach. Multiple interviews conducted by different individuals can be daunting and stressful for children (Ryan et al., 2006). Where possible and appropriate, interviews should be conducted by the same interviewer and ideally of the same sex as the child if the child so chooses (Haldorsson, 2017). As part of the interview, initial rapport-building and sustained supportive interviewer behaviour facilitates children’s comfort during interviews (e.g., Price et al., 2016).

Adapted to child’s needs

The CRC further states that States are required to ensure that children are offered child-sensitive procedures (CRC General Comment No. 5, par 24; 2003). Thus, interviews should be adapted to the child’s developmental phase and emotional state and should take into account cultural considerations and additional support needs (Davidson et al., 2006, Haldorsson, 2017). For instance, providing interpretation and translation may be helpful for non-native speakers while utilising specialised interview techniques may be beneficial for children with disabilities (Haldorsson, 2017, Mattison et al., 2015).

Research findings suggest that providing warmth and emotional support may reduce response bias; specifically, the study found that higher interviewer support (e.g., supportive behaviour during the interview) reduced omission errors in older children but increased commission errors in younger children (Eisen et al., 2019).

7 - Child-Friendly Medical Examination: The medical examination should be carried out at the Barnahus location by trained specialist medical professionals (e.g., specialists in recognising indicators of child abuse and neglect) on the same day as the forensic interview.

This core standard is supported by the Convention on the Rights of the Child, specifically that children who have experienced violence have the right to access services that would facilitate physical and psychological recovery and social integration through an environment that would nourish their health, self-respect, and dignity (CRC General Comment No. 13, par 52, 2011). Furthermore, provision of services should be immediate and without undue delay and determined through a participatory approach (Haldorsson, 2017).

Forensic medical evaluations should be conducted within the Barnahus premises by a specialist professional, such as a pediatrician, gynecologist, forensic medicine physician or a nurse with specialised training in child abuse and neglect. Research findings suggest that highly trained and experienced forensic medical specialists, especially those with a history of abuse case assessment, were less likely to develop diagnostic biases than less experienced peers (Paradise et al., 1999). This is helpful because medical examinations can impact substantiation, prosecution, and conviction rates (Smith et al., 2006), though at the same time, most forensic medical examinations tend to come back unclear (Ornolfsdottir et al., 2017).
It is helpful when forensic medical examinations are conducted very soon after suspected assault. To this point, research findings indicate that forensic medical examinations are twice as likely to occur if the child is referred to a CAC-based model compared to those referred solely to child protection services or police investigators (Smith et al., 2006; Walsh et al., 2007). For acute injury cases, Barnahus must also refer children to the hospital for further evaluation or more intensive treatment (Haldorsson, 2017).

For sexual abuse cases in particular, forensic medical examinations are integral not only to the investigative process but also to the self-recovery of the victim. Barnahus should provide a comprehensive health assessment which includes the collection of forensic evidence, diagnosis and treatment for sexually transmitted infections, mental health and health risk evaluation, and pregnancy prevention (Edinburgh et al., 2008).

8 - Child-Friendly Therapeutic Services: Therapeutic services should be offered by trained specialists knowledgeable about recovery practices after trauma and abuse, and should be offered to the child and family as soon as possible, and should include a mental health assessment as well as treatment options. Children and their families should have information about available treatment and support and can influence the timing, location and set up of interventions.

Trained specialist knowledgeable about recovery practices after trauma and abuse

Article 14.1 and 14.4 of the Lanzarote Convention emphasises that both short and long term protective measures and therapeutic assistance should be provided to children and families exposed to violence that will foster their physical and psychosocial recovery (Council of Europe, 2007). Relatedly, professionals working with victims of violence must have specialist training and knowledge of the needs of the victims so they can provide support in a neutral, respectful, and professional manner (Directive E.U., 2012).

Offered to the child and family as soon as possible

Immediate access to trauma-focussed health services may be one of the key factors for recovery. Extended periods of the investigative and judicial process conjoined with lack of access to health services may increase children’s risk of further trauma and more serious long-term consequences (Ryan et al., 2006). This may be particularly problematic in places where health services are overburdened and the referral process is lengthy.

Should include a mental health assessment as well as treatment options

Referral to individual counseling is the most common treatment for psychological trauma (Jenson et al., 1996). However, since children exposed to violence are a heterogenous group, the presentation of symptoms vary in degree and duration. It is crucial that a full mental health assessment be provided to determine the symptom profile and complete trauma history of the child (Hubel et al., 2014; Ryan et al., 2006). Treatment options should be informed by these tools and be collaboratively discussed and planned so that the child and the non-offending caregiver can make well-informed decisions.
9 - **Capacity Building**: The Barnahus service is tracked and evaluated, and staff at the Barnahus have access to monitoring and ongoing training opportunities.

The Convention on the Rights of the Child states that institutions working in the child protection system must provide general and role-specific training for all personnel, professionals and non-professionals. Jointly with educational institutions and accreditation bodies, certification schemes should be developed officially so that training experiences are acknowledged and regulated. Further, the institutions must ensure that the educational curriculum is informed by the CRC and that a rights-based approach is implemented in practice (UN General Comment No. 13, par 44, 2011).

Barnahus is the focal point for a multidisciplinary team to collaboratively investigate instances of abuse and provide support to facilitate the recovery of child victims and their families (Herbert & Bromfield, 2016). Because of this, it is important that service delivery is continuously subjected to monitoring and evaluation to keep up to date with new technological and methodological advancements and continuously adapted to the needs of the users. Evaluation studies involving multidisciplinary members, children, and their accompanying family members can help identify improvement in service provision, inform training needs of staff members, and encourage user-driven service improvement (Bonach et al., 2010; Jones et al., 2007; Muridzo & Chikadzi, 2020).

10 - **Barnahus as a Centre for Community Prevention Awareness and Knowledge Mobilisation**: Barnahus acts as a hub for prevention efforts and increasing awareness, and of training other professionals. The Barnahus also collects and shares relevant aggregate data with relevant stakeholders as a means to increase awareness and prevention efforts.

To this point, a comprehensive and reliable data collection system is encouraged to ensure the systematic monitoring and evaluation of child protection systems, and that the services provided by these institutions are aligned with their established goals and objectives (UN General Comment No. 13, par 42, 2011). The CRC also recommends engagement with media and civil society to increase awareness about violence (UN General Comment No. 13, par 44, 2011). Most importantly, children are key stakeholders and must be provided opportunities to participate in affairs that would inform research, policy, and practice (Council of Europe, 2007).

Civil societies, not-for-profit organisations, educational institutions, and the media are key players in raising awareness about violence and promoting violence prevention efforts. Barnahus is a hub that could generate knowledge and evidence, provide outreach and external competence building, and broker connections between various key actors (Haldorsson, 2017).

Children are social agents who have the right to be heard and be actively involved in matters that affect them. Thus, participatory work with children, especially those exposed to violence, should be at the heart of this core standard. Children can help Barnahus navigate the nuances of their daily lives and take part in developing strategies that address violence against children. In turn, Barnahus must ensure that children’s rights for protection and participation are equally observed and that professionals working with children are cognisant of the ethical complexities involved in this work and that they adhere to a high ethical standard (Jamieson et al, 2021).
In sum, the Barnahus model is fundamentally premised on colocation of services that are interwoven and mutually informed and that are tailored to the specific needs of children and their non-offending family members in such a way as to reduce trauma and speed the recovery of children and their families after experiencing or witnessing abuse and violence. The Barnahus model is associated with better judicial and support outcomes, and at the same time, the model supports and upholds international standards of children’s rights to participation, access of information, and reducing undue delays while reducing the trauma experienced by children and their family members during the disclosure journey and support process.

**Recommendations**

These recommendations stem from the Council of Europe (2018) recommendations for Barnahus as well as from best-practices in the research and policy literature.

1) Recommend that a “one-stop-shop” model of Barnahus, in which all procedures and services relating to justice and recovery (i.e., forensic interview including pre-recorded trial evidence, medical examination, therapeutic services and ongoing support) are provided under one roof in one location for children and their non-offending family members.

2) Propose that the use of Barnahus, as a multidisciplinary multi agency response model for children who have experienced or witnessed forms of violence, be formally incorporated into legislation to ensure equity of access for children across Scotland to the service.

3) Propose that the eligibility criteria be as broad as possible to include children who have experienced or witnessed all forms of violence (physical abuse, sexual abuse, neglect, sexual exploitation, domestic violence).

4) Recommend that any alleged adult offender receive services through another venue than the Barnahus.

5) Consider joint responsibility for Barnahus between Health and Justice sectors.

6) Propose that routine monitoring and evaluation of service provision should be part of organisational planning and budgets. Evaluation should be informed by multidisciplinary team members and the children and families who use the service. It is recommended that similar data and information is gathered across Barnahus sites to support a longer term national evaluation of services and service improvement.

7) Recommend that equitable access to service to all children is ensured, so as not to exclude children with disabilities, children of varying races and cultures, and children living in rural and remote communities.

8) Ensure that a systematic case management system is in place for multi-agency collaboration.
9) Recommend that children and their families be viewed as key stakeholders and that they be part of the development of all Barnahus decisions as active coproducers of the model and response.

10) Recommend that all forensic interviews be conducted by a specialist trained child forensic interviewer (e.g., child psychologist, child forensic interviewer) who has knowledge and experience using evidence-based interviewing protocols with children.

11) Forensic interviews are recorded to very high audio-visual specifications. The child’s face should be easily visible and voice should be audible so that recordings can be used in any court proceeding. Transcripts of the interview are not recommended in lieu of the recording for use in judicial proceedings.

12) Recommend that all non-acute forensic medical evaluations be conducted onsite in a child-friendly medical examination room at the Barnahus by a specialist doctor with experience of identifying indicators of violence and abuse against children (physical abuse, sexual abuse or exploitation, neglect).

13) Recommend that the child and non-offending family be actively involved in all aspects of the Barnahus (i.e., child and family can decline services or procedures, are involved in decision-making about the case, etc).

14) Recommend that a child advocate or similar be assigned to the child and family from the beginning of the process to the end of case completion. This advocate or similar position should follow the child and family through the process and be available as a first point of contact to provide information about any procedures within Barnahus (e.g., forensic interview, evidence-gathering).

15) Recommend that on-going therapeutic support be offered to the child and family, or be available to the family, for an extended follow-up period of time beyond case completion to avoid the child and family returning to the criminal justice/social service and health care system due to unresolved trauma or negative impacts.

16) Ensure that the child’s pathway in and out of Barnahus is integrated into current Scottish Child Planning processes and guidelines. Embedding Barnahus within the Getting it Right for Every Child planning processes will ensure children and families receive appropriate supports from education, voluntary sector, health and social services. Thus, children who are being seen at Barnahus have the means for any services to be adapted for their needs while they have an open case with Barnahus and an informed plan of action for the child once the child’s case is closed with Barnahus.
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https://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf


Appendix A: Literature Searching Method

We conducted a comprehensive literature searching method to source literature relating to:

(1) Best practices used in responding to child victims and witnesses of all types of abuse and harm, including the principles and evidence base behind such recovery-based integrated practice models

(2) Effects of experiencing and witnessing trauma and abuse on children, young people and their families, including prevalence information and impact of COVID-19 on violence against children, as well as the support requirements of children and families during the judicial and recovery journal following trauma or abuse, with considerations to those with protected characteristics under the Equality Act (2010)

We conducted both a systematic (first subject topic above) and scoping review (second topic above), following the guidelines listed under the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) and Scoping Reviews (PRISMA-ScR). In our search, we included primary and secondary research studies, statistical overviews, government reports, and conceptual and theoretical papers. Electronic databases were searched to identify a range of literature of relevance and included legal (criminology, law), social science (social work, psychology) and health databases, given the multidisciplinary nature of the subject. The European PROMISE network was also consulted, as were government department websites and third-sector agencies (e.g., the National Child Advocacy Centre website, Children 1st, NSPCC).

Summary information from all of the studies identified from the electronic searches was reviewed and directly relevant studies were shortlisted and imported into a database for a more detailed examination of the full text. Additional reports from the ‘grey literature’ website searches were also screened and those that were relevant were assessed in detail. Finally, we used a qualitative review methodology to assess thematic content across the topic areas, and provide a synthesis of the knowledge base in our report.