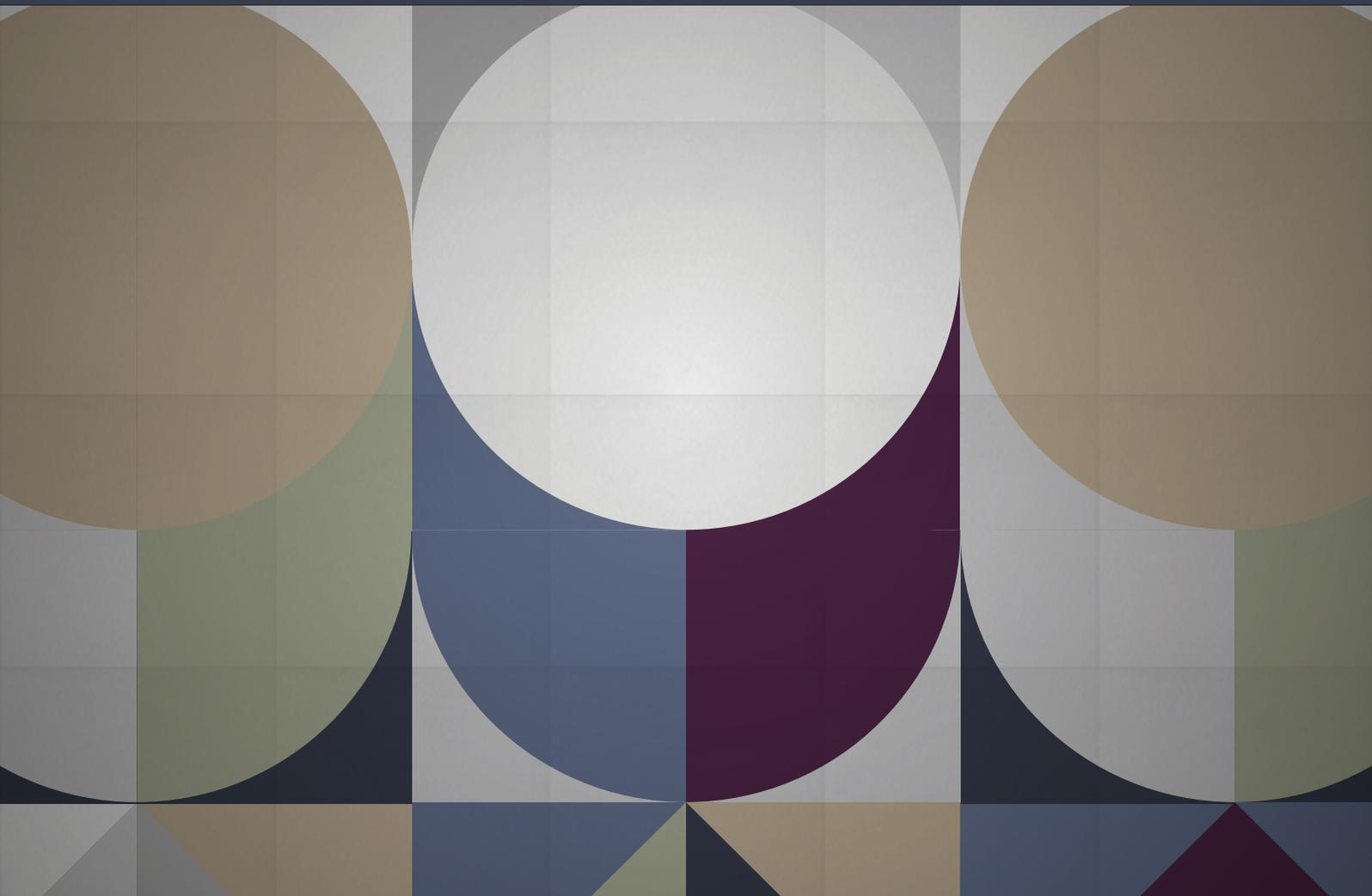


Interventions for Intrafamilial Physical Abuse and Violence Against Children

JANUARY 2026

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Summary

Context:

Rising concern in Scotland: In 2024 - 25, Police Scotland recorded 776 cases of cruelty to or maltreatment of children, a 26% increase on the previous year and 8% higher than in 2015- 16, highlighting the urgent need for evidence-based responses to physical abuse. The most common referral leading to an Inter-agency Referral Discussion (IRD) in Aberdeen and Aberdeenshire is intrafamilial physical assault, with many children remaining at home with the alleged perpetrator if it is felt to be the most proportionate response and in the child's interests.

Methodology

This rapid review synthesised 32 studies from high-income countries, predominantly the United States (53%), Canada (13%), and Sweden (13%), with smaller contributions from the UK (6%) and others. Evidence from low- and middle-income countries remains sparse.

Key findings

Intervention settings: Most interventions were delivered in community (44%) and child welfare/protection settings (28%), which is important because these environments naturally bring together multiple services and professionals, ideally making support more accessible, coordinated, and responsive to families' complex needs. Smaller proportions were situated in clinical or healthcare environments (n = 4; 13%), home-based interventions (n = 3; 9%), and educational settings (n = 1; 3%). One study (3%) was conducted in a secure residential facility for young people in custody.

Target populations: The majority of interventions addressed parents or caregivers responsible for, or at risk of, physical abuse, alongside children exposed to physical or domestic violence. Many programmes supported both groups jointly to rebuild relationships and prevent recurrence.

What works:

- Parent–Child Interaction Therapy (PCIT), CPC-CBT, and SafeCare achieved reductions in re-abuse reports and improvements in child–parent relationships.
- Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) and trauma-informed system reforms enhanced multi-agency coordination and practitioner confidence.
- Trauma-focused child therapies improved emotional regulation, attachment, and recovery outcomes.

Mechanisms of change: Effective interventions combined (1) behavioural skill-building for caregivers and (2) trauma recovery and relational repair for children, and were supported by (3) system-level enablers, such as consistent funding, cross-agency training, and staff supervision, which acted as the contextual conditions that made these interventions possible and more effective. Interventions delivered within environments that provide stable resources, well-trained multi-agency practitioners, and regular supervision are more likely to achieve positive and sustained outcomes.

Alignment with Bairns' Hoose: Models that integrated child voice, therapeutic safety, and multi-agency collaboration most closely reflected the Bairns' Hoose ethos, offering trauma-informed, child-centred, and rights-based responses to violence.

Evidence gaps: Key gaps concern equity and inclusion, particularly for minority and low-income families, disabled children and long-term follow-up on children's safety and wellbeing.

Policy implication: Scotland's Bairns' Hoose Pathfinder can build on this evidence by embedding child-inclusive, trauma-informed interventions within multi-agency governance structures, supported by sustained supervision making sure the approach is carried out the way it was designed. CSE is a form of child sexual abuse where an individual or group exploits an imbalance of power to coerce, manipulate or deceive a person under 18 into sexual activity in exchange for something the victim needs or wants, or for the perpetrator's financial gain. Exploitation can occur even if the sexual activity appears consensual (National Guidance on Child Protection in Scotland, 2023).

1. Context and Rationale

Reports of child physical abuse in Scotland have risen sharply in recent years. In 2024 - 25, police recorded 776 cases of cruelty to or maltreatment of children, up 26 per cent from the previous year and 8 per cent higher than in 2015 - 16 (1,2). These figures highlight persistent and growing concerns about serious harm to children and the need for effective, evidence-based interventions.

Children exposed to physical abuse or domestic violence face long-term risks to their safety, wellbeing, and development. Such experiences often occur alongside other adversities, including neglect, parental substance misuse, or community violence, which intensify harm and complicate protection efforts.

Modelled on the Icelandic Barnahus (3), Bairns' Hoose aims to provide a trauma-informed, child-centred, and rights-based response integrating justice, health, social work, and recovery supports. To strengthen practice, professionals require clear evidence on which interventions work, in which settings, and how they promote children's recovery and safety.

This rapid review examines how practitioners and services respond to intrafamilial physical abuse and violence, particularly where children continue to live with the alleged perpetrator. It forms part of the Bairns' Hoose Pathfinders in Aberdeen and Aberdeenshire, where the most common referral to Inter-agency Referral Discussion (IRD) involves intrafamilial physical assault. Many cases concern children who remain in the family home alongside the alleged perpetrator. Accordingly, this review focuses on the multidisciplinary response to intrafamilial physical abuse and violence, with particular attention to the complexities of safeguarding where continued co-residence with perpetrators is a feature.

2. Background and approach

This rapid review aimed to bring together reliable evidence on practitioner-led interventions designed to support children and young people who had experienced physical abuse or violence within their family. The focus was on approaches delivered by professionals in education, social care, health and justice settings as well as at home; with attention to how effective, feasible, and acceptable these interventions were in real-world practice.

Because timely evidence was needed to guide policy and frontline work, a rapid review approach was used. This allowed for a streamlined but still systematic process. The rapid review was registered before searches began (4), we then carried out focused searches across major academic databases and grey literature sources, applied predefined eligibility criteria, and used structured data extraction. The review included a range of study types, from trials to observational and qualitative research that explored experiences of receiving or delivering an intervention.

To ensure relevance to current practice, only studies published in the past 10 years were included initially, this was extended by a further 10 years to 2005 after reviewing had started. Although processes such as screening and data extraction were not fully duplicated, 20% of each stage was independently checked to maintain rigour while working within the accelerated timeframe. Findings were synthesised narratively, summarising the types of interventions identified, the children and families they supported, the practitioner roles involved, and the factors that influenced their implementation and effectiveness.

3. Review Questions

- What interventions have been implemented to address intrafamilial physical abuse and violence against children and young people in the UK and internationally?
- How do these interventions support recovery, protection, and safeguarding needs?
- What outcomes are reported in relation to children's safety, wellbeing, and longer-term recovery?

A secondary question explores how evidence from the UK and beyond can inform the ongoing development of Bairns' Hoose and related services across Scotland.

3.1 Definition

Physical abuse is defined as causing physical harm to a child or young person, including hitting, shaking, throwing, poisoning, burning, scalding, drowning, or suffocating.

4. Results and Evidence Base

The evidence base is concentrated in high-income countries, with most studies conducted in the United States (n = 17; 53%), followed by Canada (n = 4; 13%), Sweden (n = 4; 13%), and the United Kingdom (n = 2; 6%). Additional studies were identified in Belgium (n = 1; 3%), Australia (n = 1; 3%), and India (n = 1; 3%), while two multi-country reviews synthesised findings across high-income settings such as the USA, Canada, UK, Australia, New Zealand, and Western Europe.

Across all studies, interventions were most frequently delivered in community-based settings (n = 14; 44%) and within child welfare or protection settings (n = 9; 28%), underscoring the central role of statutory and community services in addressing child protection and trauma. Community based settings are locally embedded environments such as schools, early years centres, neighbourhood organisations, youth clubs, family resource centres, community halls, libraries, faith-based venues and other non-residential services where practitioners can deliver support directly to children and families in their own communities. Smaller proportions were situated in clinical or healthcare environments (n = 4; 13%), home-based interventions (n = 3; 9%), and educational settings (n = 1; 3%). One study (3%) was conducted in a secure residential facility for young people in custody.

This distribution highlights that intervention evidence is largely situated within community and statutory child welfare environments in high-income countries, with limited evidence from low- and middle-income countries.

4.1 Methodological Overview

The studies we found mostly used quantitative study designs, such as trials and before-and-after comparisons, to examine whether interventions were associated with changes in outcomes. These designs allow for the assessment of change over time and comparison across conditions; however, the level of confidence that can be placed in individual findings varies according to factors such as study quality, implementation fidelity, sample size, and risk of bias. A smaller set of studies used interviews, observations or mixed approaches to explore how programmes were delivered and how families and practitioners experienced them. We also included a few reviews and papers that focused on ideas or guidance rather than new data.

There are limits to what this review can show. We widened the search to include an extra decade of research and studies from other countries, which helped capture more examples but also increased variation in context, services and evidence quality. This means the findings should be interpreted with care because not all interventions were designed for, or tested within, settings comparable to our own. Over half of the included studies represent an American context.

4.2 Intervention Types and Who They Support

Across the studies, most interventions fell into three broad groups, each designed to support children who have been harmed and/or the adults who care for them. A glossary of all the interventions and their description can be seen in Annex 1, and Table A1 (list of included studies with relevant summary information) can be seen in Annex 2.

4.2.1 Programmes for Parents and Parents Working with Their Children

Many interventions focused on helping parents or caregivers of children aged up to twelve who were involved with child protection services because of confirmed or suspected physical abuse (5). These programmes aimed to support families to understand their behaviour and/or replace harmful discipline with safer, more positive ways of managing behaviour and building relationships.

- *Parent–Child Interaction Therapy (PCIT)* and similar coaching models worked with parents who had used physical punishment or other harmful behaviour. Practitioners observed the parent and child playing together and gave the parent live guidance through an earpiece, helping them practise calm, consistent and non-violent parenting (6–8).
- *SafeCare, Triple P and Project Support* were offered to parents referred by child protection, mental health or home-visiting services. These programmes taught practical skills such as child-safe home routines, positive behaviour management and coping strategies for stress (9–13).
- *Caring Dads* worked specifically with fathers who had used violence or exposed children to domestic abuse. It focused on accountability, empathy and developing parenting skills that protect rather than frighten children (14).
- A *structured home-visitation programme* delivered by public-health nurses over two years. Families received weekly visits for the first 6 months, biweekly visits for the next 6 months, and monthly visits for the final 12 months. Each visit lasted around 1.5 hours and involved at least one parent (both when possible). Visits focused on strengthening parenting skills, monitoring child development, and providing tailored support (15).

4.2.2 Therapies for Children Affected by Trauma

All interventions aimed at children were therapeutic in nature; some interventions were designed directly for children who had been physically abused, exposed to domestic violence or experienced ongoing trauma. These were usually delivered in community clinics, schools or outpatient services.

- Therapies such as *Progressive Counting and Imagery-Based CBT* helped children process frightening memories and reduce the emotional distress linked to past harm (16–19).
- *I-INTERACT* and *school-based art therapy* combined skill-building with creative activities to help children express themselves, manage strong emotions and strengthen their relationships with caregivers. These approaches prioritised children’s voices, empowerment and emotional safety (5,20–24).
- *Combined Parent–Child Cognitive Behavioural Therapy (CPC-CBT)*, used in the USA and Sweden, brought together children who had been physically hurt and their caregivers. It supported families to talk about the abuse safely, understand its impact and rebuild trust while helping children manage trauma-related feelings and behaviours (25–30).

4.2.3 Interventions That Work Across the Whole System

A smaller number of programmes aimed to improve not just family-level support but also the wider system around the child. This included models like *Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)*, *Trauma-Informed Leadership Teams (TILTs)*, the *Massachusetts Child Trauma Project* and the *Bikers Against Child Abuse (BACA)* (6,23,31–36). These initiatives trained social workers, mental health practitioners and child protection workers in trauma-informed practice and improved coordination between agencies. Their goal was to ensure that children received consistent protection and timely access to therapeutic help, no matter which service they entered through.

5. Implementation and How These Interventions Create Change

Across the studies, programmes were delivered in many different settings, including child welfare services, mental health clinics, hospitals, schools, and family support agencies. Although the approaches varied, they tended to create change through three connected pathways:

5.1 Supporting caregivers to change their behaviour

Many programmes focus directly on helping parents or caregivers develop safer, more nurturing ways of interacting with their children. They typically do this by:

- Showing parents helpful skills (e.g., positive reinforcement, calm communication)
- Practising these skills together
- Providing real-time coaching or feedback while parents interact with their child

Well-established programmes such as Parent–Child Interaction Therapy (PCIT) and SafeCare were found to strengthen parental warmth, reduce harsh or coercive discipline, and help parents manage stress and emotions more effectively.

Delivering support in the home or community often increased attendance and helped families feel more comfortable. Programmes that included motivational interviewing or engagement sessions were especially helpful for caregivers who were initially uncertain or overwhelmed.

5.2 Helping children heal from trauma and strengthening family relationships

Other interventions focused on children’s emotional recovery and the parent–child relationship.

Approaches such as *trauma-focused CBCT*, *play therapy*, and *joint parent–child sessions* helped children:

- Make sense of what happened to them
- Reduce feelings of fear, shame, or self-blame
- Build confidence in their own safety and boundaries

At the same time, these therapies worked with parents to increase empathy, understand the impact of trauma, and take responsibility for creating a safer home environment. This combination of child healing and relational repair was key to rebuilding trust.

5.3 Improving the systems that support families

Some programmes worked at a broader system level rather than with individual families alone.

Models such as *Multisystemic Therapy for Child Abuse and Neglect* MST-CAN and state-wide trauma-informed initiatives aimed to:

- Train professionals to deliver consistent, evidence-based care
- Improve collaboration between agencies (e.g., child welfare, mental health, schools)
- Create clearer pathways for referrals and follow-up support

However, these system-level improvements were often limited by practical challenges. High caseloads, staff turnover, and funding constraints meant that many trained practitioners struggled to implement these models fully or consistently. As a result, even strong programmes sometimes fell short of reaching all families who could benefit.

6. Reported Outcomes and Challenges

6.1 Outcomes

Keeping children safe

Across many high-quality studies, programmes with the strongest evidence of success for protecting children were the ones that offered intensive, hands-on support in families' homes. Programmes like PCIT, *Project Support*, *SafeCare*, and MST-CAN consistently reduced the chance that abuse or neglect would happen again (6,8–10,13,19,35). For example, *SafeCare* lowered repeat maltreatment by about 20%, and families in *Project Support* were far less likely to be re-reported to child protection services (9,10). The strongest results appeared when programmes were well-supervised, started early, and involved regular home visits. Some home-visiting programmes showed weaker or mixed results, especially when they were short, inconsistently delivered, or when families didn't stay involved for long enough.

Helping children heal emotionally

Therapies that involve both children and their parents, like CPC-CBT, I-*In*TERACT, and *Progressive Counting* (16,20,26–28) helped children recover from trauma. Children showed big improvements in anxiety, stress, anger, and PTSD symptoms, and felt safer and more connected to their caregivers. These benefits were strongest when children were helped to talk about what happened in a safe way, and when parents were supported to respond calmly and predictably. Creative and play-based therapies also helped children express feelings and build confidence, though they sometimes faced practical challenges such as privacy or limited space (7,8).

Improving parents' skills and emotional wellbeing

Many programmes helped parents reduce harsh or inconsistent discipline and become more patient, warm, and confident. PCIT and CPC-CBT produced especially strong improvements in parenting, while Triple P showed benefits lasting several years (6–8,25–30). Father-focused programmes like *Caring Dads* improved co-parenting and communication, although changes in aggressive behaviour were more modest (14). Some studies also found that parents were more likely to stay in treatment when motivational support was added early, especially for those who felt unsure about change.

6.2 Challenges

Lack of capacity: strengthening the system around families

Workforce training and trauma-informed initiatives improved professionals' understanding and increased collaboration across services (37,38). However, these improvements did not always lead to more children actually receiving specialist trauma therapy, due to services being overstretched or families having trouble accessing them (32). Studies of "usual services" showed that support was often inconsistent, low-intensity, and not based on the best available evidence, highlighting the need for better resources, supervision, and structured interventions.

Lack of equity: reaching all families fairly

Very few studies reported how well programmes worked for different groups, such as ethnic minority families, low-income households, or children with disabilities. Where information was available, some programmes, like *SafeCare* and *MST-BSF* (9,10,33,35), worked well in diverse and high-stress communities, especially when adapted to cultural and practical needs. Nordic studies also emphasized the importance of language support and cultural sensitivity. Overall, the lack of data on certain groups is a major gap, making it harder to know whether services are truly reaching those who need them most.

7. Comparison of Review Findings with the NICE Guidelines

The interventions identified in the review fit well with recommendations from the NICE Child Abuse and Neglect guidelines (39), but the review also adds newer and broader approaches. Both sources agree that the most important goal after physical abuse is to help parents or carers build safer, warmer, and more responsive relationships with their children. They also agree that support should ideally happen in the home or community setting, be tailored to each family's needs, and focus on helping parents use consistent, non-violent approaches to discipline. Table 1 summarises key comparison points between the NICE guidelines and this review.

It is important to note that the NICE guidelines address child abuse and neglect in its full breadth, encompassing physical abuse, emotional abuse and neglect, whereas the present review is deliberately focused on physical abuse only. As such, the comparison that follows should be interpreted as a partial alignment exercise, examining points of convergence and divergence within a narrower evidential scope.

For very young children, the NICE guidelines emphasise attachment-based therapies that help parents become more sensitive and less frightening during their interactions with their child. Programmes such as *Attachment and Biobehavioural Catch-up* or *Child–Parent Psychotherapy* help parents understand how their own childhood experiences might influence the way they respond to their child. The review includes approaches like *Parent–Child Interaction Therapy*, *SafeCare*, and *Combined Parent–Child CBT*, all of which similarly aim to strengthen parent–child relationships and support parents to stay calm, responsive, and nurturing. These programmes closely match NICE's focus, although the review describes a wider range of practical and coaching-based methods than NICE lists.

For primary-school-aged children, both the NICE guidelines and the review highlight structured parenting programmes that teach parents how to manage behaviour safely and positively. *SafeCare* and *Parent-Child Interaction Therapy* appear in both sources, showing strong agreement about their usefulness. The review also adds other well-known programmes, such as *Triple P*, *Project Support*, and the online intervention *I-InTERACT*, which expand on the options NICE describes. These additional programmes all share the same core goals of improving routines, reducing stress, and helping parents manage difficult moments without resorting to harsh or frightening discipline.

For older children and teenagers, NICE recommends more intensive, full-family support such as *Multi-Systemic Therapy for Child Abuse and Neglect (MST-CAN)*. This matches the review, which also includes MST-CAN but adds further options. These include programmes for abusive fathers (such as *Caring Dads*), trauma-focused therapies for children (like *Progressive Counting and Imagery-Based CBT*), and creative therapies like school-based art therapy. NICE notes that there are gaps in the evidence for adolescents, and the review helps fill some of those gaps by presenting a wider range of approaches that support both the young person and the family.

The review also goes beyond the NICE guidelines by describing interventions that work at a

community or system level. These include trauma-informed leadership teams, mentoring schemes, support programmes for foster carers, and school-based consultation. NICE focuses mainly on direct therapeutic work with children and parents, while the review highlights how wider systems: schools, social care and community organisations, can also contribute to stability, safety, and recovery.

Overall, the interventions in the review strongly reflect what NICE recommends: helping parents become more nurturing, improving communication between parents and children, and creating safer home environments. At the same time, the review offers a broader and more up-to-date picture, including newer digital programmes, more trauma-focused treatments for children, and stronger emphasis on community and organisational support.

Table 1 Key areas of comparison between The NICE Child abuse and neglect guidelines (2017) (39) and the review findings

Area	NICE Guidelines	Review Findings	Comparison
Attachment-Based Interventions (Under 5)	Strong emphasis	PCIT, CPC-CBT, SafeCare, Project Support	High alignment; review adds behavioural models
Parenting Programmes (Under 12)	SafeCare, PCIT, KEEP	Triple P, I-INTERACT, CPC-CBT	Expands NICE with digital and CBT-based options
Adolescents (10–17)	MST-CAN	MST-CAN + Caring Dads + trauma therapies	Review fills NICE’s acknowledged evidence gaps
Child-Focused Trauma Therapies	Limited detail	Progressive Counting, Imagery-CBT, Art Therapy	Review provides substantial additions
System-Level Interventions	Minimal	TILTs, Massachusetts Project, school-based support, BACA	Review highlights multi-level ecological approaches
Focus on Non-Violent Parenting	Core principle	Consistent across PCIT, SafeCare, Triple P, BACA	Fully aligned

8. Relevance to Bairns' Hoose Development

The rapid-review evidence suggests that Bairns' Hoose will work best when it uses approaches that are structured, supportive, and trauma-informed. Strong evidence from programmes like PCIT and *motivational support work* (7,8) shows that helping parents practise new skills in real time and keeping them engaged can reduce the chances of children being harmed again. Other programmes, such as *SafeCare* (9), show that regular home-based support focusing on safety in the home, building positive relationships, and solving everyday problems can lower the risk of future maltreatment. Large parenting programmes like *Triple P* (11,12) also demonstrate that when parents receive clear, practical guidance, they are less likely to use harsh discipline and children's behaviour and wellbeing improve.

Whole-system approaches, such as the *Massachusetts Child Trauma Project* (32), highlight how important it is to have a well-trained workforce and good communication between services. This is highly relevant for Bairns' Hoose, which will need strong coordination across health, social work, education, police, and recovery support teams so that children get the right help quickly.

Therapies designed specifically for children who have experienced trauma, such as *Progressive Counting* (16), *CPC-CBT* (25,29,30), and creative or play-based approaches (21,24), show that children recover better when they feel safe, understood, and supported to make sense of what happened to them. These approaches fit closely with the aims of Bairns' Hoose to be child-centred, therapeutic, and protective. Family-focused programmes like *MST-BSF* (33), *Project Support* (13), and *Caring Dads* (14) also show that helping parents with their own challenges, such as mental health problems, substance use, or harmful behaviour, is essential for keeping children safe in the long term.

On the other hand, studies of less structured or low-intensity services show little or inconsistent benefit (5,15,34).

9. Strengths, Gaps, and Future Priorities

9.1 Strengths

Strong evidence about what helps children recover

Research from many countries shows that children who experience physical abuse or violence do best when they receive structured, trauma-informed support from trained professionals. Programmes like parenting support, home-visiting, and child-focused therapies help improve safety, strengthen relationships, and support emotional recovery. This gives Scotland a strong starting point.

Strong fit with Scotland's approach (GIRFEC)

Much of the international evidence aligns closely with Scotland's *Getting It Right For Every Child* (GIRFEC) framework (40). The most effective programmes are child-centred, coordinated across services, and focused on early help; all key principles of GIRFEC and the *Bairns' Hoose* model.

Supportive policy and practice environment

Scotland already has national commitments to trauma-informed practice, children's rights, early intervention, and multi-agency working. This means the wider system is well-placed to introduce evidence-based support for children affected by physical abuse and violence.

9.2 Gaps

Limited evidence from Scotland or the wider UK

Most research comes from the US, Australia, and Europe. There is not yet enough evidence about what works specifically within Scottish services, systems, and communities, including how *Getting It Right For Every Child* (GIRFEC) (40) and *Children's Hearings* (41) shape children's experiences.

Some children are missing from evidence

There is very limited research focusing on children with disabilities, older children and teenagers, and families experiencing multiple and complex difficulties. These groups are under-represented in the existing evidence base, meaning that services and interventions may not fully reflect their needs or circumstances. As a result, particular attention will be required in Scotland to ensure that support is appropriately designed, accessible, and responsive to the specific challenges faced by these children and families.

Workforce pressures affect what support can be delivered

The most successful programmes require skilled practitioners, protected time, and ongoing supervision. Scotland faces challenges across social work, psychology, health, and education in terms of capacity, workload, and recruitment, all of which affect what can realistically be offered. The 2023-24 Chief Social Work Officer Survey Report highlights ongoing issues with recruitment and retention of social workers alongside workload pressures (4s2). Similarly The Educational Institute of Scotland report similar evidence of challenges of retention within the Education sector (43).

Lack of long-term follow-up

Most studies measure outcomes over a short period. We know far less about what helps children and families sustain progress over years. Scotland will need better long-term data to understand whether Bairns' Hoose and GIRFEC-aligned support lead to lasting change.

Conclusion

This rapid review provides an overview of the best available evidence on practitioner-led support for children and young people who have experienced physical abuse and violence. The findings offer a helpful picture of what approaches appear to support children's safety, recovery, and wellbeing. Across the studies examined, interventions that are trauma-informed, child-centred, and delivered by trained practitioners tended to show the most promise.

At the same time, the evidence base has limitations. Much of the research comes from other countries with different service systems, and certain groups of children, and Scottish contexts specifically, are underrepresented in the existing literature. These gaps mean the findings should be interpreted with care, and they highlight the need for more Scotland-based studies to strengthen the evidence that underpins practice here.

Even with these limitations, the review points to a clear direction of travel. Scotland already has a strong policy foundation through GIRFEC and the developing Bairns' Hoose model, both of which align with the principles seen in promising international interventions. By continuing to invest in skilled practitioners, improving coordination between services, and embedding evidence-informed support within GIRFEC pathways, Scotland can further strengthen how children are protected and helped to recover.

Delivering these approaches effectively will require strengthened workforce support, including ongoing training, supervision, and protected time for practitioners, so that children receive trauma-informed and well-coordinated help. Scotland should also ensure support is tailored for those with the greatest needs, such as disabled children, teenagers, and families facing multiple challenges, who were less represented in the reviewed studies but remain a key part of Scotland's population. Finally, building a shared national approach to data, learning, and evaluation across Bairns' Hoose sites would support continuous improvement and help identify what works and where further development is needed.

As Bairns' Hoose continues to evolve, the insights from this rapid review can support decision-makers, services, and practitioners to shape responses that are safe, compassionate, and centred on the rights and needs of children.

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Annex 1 - Intervention Glossary and Descriptions

Parent–Child Interaction Therapy (PCIT)

PCIT is a hands-on coaching programme where a practitioner observes the parent and child playing together and gives the parent real-time guidance through a small earpiece. The practitioner helps the parent stay calm, follow the child’s lead, praise positive behaviour and use firm but non-violent boundaries. Over time, parents learn alternative ways to respond to stress or misbehaviour and build a warmer, more consistent relationship with their child.

Combined Parent–Child Cognitive Behavioural Therapy (CPC-CBT)

CPC-CBT brings a child who has experienced physical abuse together with their caregiver in a structured therapy programme. The therapist helps the child understand and manage trauma-related emotions while also helping the caregiver learn safer, more supportive parenting. Families often work through a gradual process of discussing the abuse in a safe way, rebuilding trust, and learning new skills for communication and emotional regulation.

SafeCare

SafeCare is a home-visiting programme where trained workers teach parents practical day-to-day skills: creating safe home environments, planning positive routines, supervising children appropriately and using non-violent behaviour management strategies. Sessions take place in the family home so parents can practise in real situations and receive supportive feedback.

Triple P (Positive Parenting Programme)

Triple P offers a stepped range of parenting support, from short advice sessions to longer one-to-one coaching. It teaches parents how to understand their child’s behaviour, encourage positive habits and manage difficult moments without resorting to harsh discipline. It is highly structured but adaptable, so families receive the level of support that suits them.

Project Support

Project Support provides intensive, in-home coaching for families leaving domestic violence refuges or involved with child protection services. Practitioners help parents manage their child’s behaviour, reduce stress in the home and strengthen the parent–child bond. The programme also helps families access housing, financial support and community services.

Caring Dads

Caring Dads works with fathers who have used violence or exposed children to domestic abuse. The sessions increase understanding of how abusive behaviour affects children, build empathy and teach safer ways of relating to co-parents and children. Fathers practise skills for managing anger, communicating respectfully and taking responsibility for their actions.

Motivational Intervention and Enhancement

Motivational Intervention is a focused, evidence-based approach used to help parents increase their motivation, readiness, and commitment to behaviour change that supports their child’s safety and wellbeing. It draws on principles of Motivational Interviewing (MI) to explore ambivalence, highlight discrepancies between current behaviours and parenting goals, and

build the parent's confidence in their ability to change. By fostering a collaborative, non-judgemental dialogue, MI enhances engagement with services and prepares parents to participate more effectively in wider parenting, therapeutic, or support programmes.

Motivational Enhancement

Motivational Enhancement is a structured, time-limited intervention that originates from Motivational Interviewing (MI), an evidence-based counselling approach to strengthen a person's intrinsic motivation for change. Motivational Enhancement can be understood as a specific, manualised form of motivational intervention that uses the "spirit" and methods of MI to help people build readiness and confidence to change behaviours affecting their well-being or their children's wellbeing.

Child-Focused Trauma Therapies

Progressive Counting

Progressive Counting is a trauma-processing method similar to other evidence-based therapies for post-traumatic stress. The child tells the story of what happened in short sections while the therapist guides them through a counting sequence. The goal is to help the child gradually face the memory in small, manageable steps so it becomes less distressing. Over time, strong emotional reactions reduce and the child feels more in control of their thoughts and feelings.

Imagery-Based Cognitive Behavioural Therapy (Imagery-CBT)

Imagery-CBT helps children work with the mental pictures, sensations or memories that often resurface after physical abuse or exposure to violence. The therapist teaches techniques to change frightening or overwhelming images into safer and more manageable ones. Children learn new coping skills, practise calming strategies and build confidence in re-shaping how the traumatic memory affects them.

I-InTERACT

I-InTERACT is an online or clinic-based programme that teaches parents how to support children with emotional and behavioural difficulties linked to trauma. Parents watch short videos, practise positive parenting skills and receive coaching to help them respond more calmly and consistently. Children benefit through improved routines, emotional regulation and more predictable caregiving.

School-Based Art Therapy

In school-based art therapy, children use drawing, painting, modelling and other creative activities to express feelings they might not yet have words for. A trained therapist helps the child make sense of their artwork and use creativity as a safe outlet for fear, worry or anger. This approach is particularly helpful when children struggle to talk directly about their experiences.

Multisystemic and System-Level Interventions

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)

MST-CAN is an intensive, whole-family intervention delivered mostly in the home. A team supports not only the child and parent but also the networks around them, such as school staff, extended family and community services. The team works on improving parenting, reducing conflict, managing stress, addressing mental health or substance use issues and strengthening safety planning. Support is available 24/7, and therapists work with only a few families at a time to provide intensive help.

Trauma-Informed Leadership Teams (TILTs)

TILTs train child welfare and mental health practitioners to recognise the impact of trauma and respond in ways that avoid re-traumatising children. They provide staff training, coaching and organisational guidance so agencies can create safer, more predictable environments for children and families.

Massachusetts Child Trauma Project

This project strengthens the child welfare system by improving screening for trauma, expanding access to evidence-based therapies, and training professionals to work together more effectively. It aims to ensure that every child who has experienced abuse or violence is recognised early and referred to the right support.

Community, School and Volunteer Support Models

Bikers Against Child Abuse (BACA)

Bikers Against Child Abuse (BACA) is an international volunteer organisation that helps children who have experienced abuse feel safe, supported, and empowered. BACA offers four levels of intervention depending on the child's needs, most commonly beginning with a Level 1 visit, where members from a local chapter ride as a group to meet the child, present them with a vest and patches, and give them a teddy bear with the chapter's phone number. Each child is assigned two trained primary contacts they can call any time, day or night, and these members maintain regular check-ins and provide a calm, reassuring presence at the child's home or when the child feels afraid. If harassment or intimidation continues, BACA may activate a Level 2 response, offering increased presence and escorting the child to school or other required places until the situation stabilises. Levels 3 and 4, used extremely rarely, involve formal, court-approved communication to the alleged perpetrator and neighbourhood awareness rides to signal the community's support for the child; actions designed to deter further contact while strictly avoiding confrontation. BACA members also accompany children to court, sitting with them in waiting rooms, supporting them in the courtroom, and escorting them throughout the process. At every stage, BACA coordinates closely with law enforcement and judicial authorities and strictly prohibits any form of vigilante behaviour, focusing instead on providing emotional security and helping children regain confidence after trauma.

Community Mentoring

Mentoring programmes pair children with trained volunteers or youth workers who meet regularly to provide emotional support, guidance and positive role modelling. These mentors help children build confidence, manage daily challenges and feel connected to safe adults.

Foster Care Support Programmes

These interventions provide extra help to children living in foster homes, such as therapeutic support, practical advice for caregivers or joint sessions to improve communication. Foster carers receive coaching on managing trauma-related behaviours and promoting stability for the child.

School-Based Support and Consultation

Teachers and school staff may receive training, consultation or supervision to help them understand trauma and respond safely when children show distress or behavioural difficulties. This helps create a more predictable and calming school environment for children recovering from abuse.

Annex 2 – List of studies with key information

Table A1 List of included studies with relevant summary information

Study (Author, Year)	Country	Type of Harm (Physical abuse, violence, assault, weapon use)	Intervention Description and Approach	Approach	Relevance to Bairns' Hoose Principles	Outcomes (Short Summary)	Notes (Short Practitioner Insights)
Barlow et al., 2006	Primarily USA, UK and Canada	Physical abuse and neglect	Parent–Child Interaction Therapy, Webster-Stratton Incredible Years, CBT, multisystemic family therapy, behavioural parent training.	Skills-based behavioural and relational therapies	Evidence-based parenting programmes that strengthen relational safety, improve parenting capacity and support trauma-informed recovery.	Some programmes reduce physical abuse; strongest effects for early, long, well-implemented interventions.	Need early, sustained, high-quality delivery; effects vary by context.
Barron & Tracey, 2018	Scotland, UK	Child maltreatment with trauma exposure (including physical abuse and neglect)	Progressive Counting, a phased trauma-exposure therapy adapted for secure accommodation.	Trauma-informed phased exposure, narrative processing, distress reduction	Enhances safety, supports child narrative autonomy, regulates exposure, and aligns with child-centred trauma recovery.	Reduced distress; better emotional regulation; challenges with confidentiality and secure-setting constraints.	Brief exposure work feasible but complex in institutional settings.
Barto et al., 2018	USA	Physical abuse, neglect, and broader maltreatment in child-welfare caseloads	Trauma-Informed Leadership Teams; large-scale training in ARC, CPP, TF-CBT; system-wide trauma reform.	Multi-agency system reform, trauma-informed workforce training	Strong alignment with trauma-informed system integration and collaborative pathways central to Bairns' Hoose.	Improved trauma-informed practice; low access to EBTs; system-level gaps remain.	Training improves culture but not enough without treatment access.
Berberian, 2020	USA	Physical abuse, neglect, and exposure to domestic/community violence	Strengths-based and relational art therapy for traumatised youth.	Creative, relational, empowering	Supports participation, empowerment and emotional recovery; provides safe, creative therapeutic environments.	Better emotional regulation, self-expression, resilience; systems barriers persist.	Creative, strengths-based work supports trust and healing.

Study (Author, Year)	Country	Type of Harm (Physical abuse, violence, assault, weapon use)	Intervention Description and Approach	Approach	Relevance to Bairns' Hoose Principles	Outcomes (Short Summary)	Notes (Short Practitioner Insights)
Chaffin et al., 2011	USA	Physical abuse and harsh physical discipline (substantiated cases)	Parent-Child Interaction Therapy with Motivational Intervention (MI).	Live-coached behavioural parent-child therapy	Relational and skills-based therapy supporting non-violent parenting and child safety.	PCIT delivered with MI reduced re-reports; better parenting; attrition and fidelity challenges. No significant changes for PCIT or MI alone	Feedback-based coaching builds parental empathy and skills.
Chaffin et al., 2012	USA	Neglect and physical abuse (majority neglect; some sexual abuse; mixed maltreatment types)	SafeCare: structured home-visiting modules on safety, health, and parenting.	Manualised home-visiting, behavioural skills, safety and health modules	Strong focus on prevention, child safety and family empowerment; mirrors integrated, trauma-informed care.	SafeCare reduced recidivism; strongest for typical inclusion families; coaching mixed.	Structured model feasible state-wide; valued by home visitors.
Chaffin et al., 2009	USA	Chronic neglect with some physical abuse (child-welfare referrals)	Motivational intervention plus PCIT for low-motivation parents.	MI-based readiness building, followed by PCIT	Enhances parental engagement and relational safety; supports trauma-informed family change.	Motivational enhancement + PCIT improved retention; strongest effect for low-motivation parents.	Target motivation selectively, not universally.
Dennis & Leigh, 2021	Belgium	Physical abuse (alleged assault causing bruising)	Ethnomethodological, relationship-based social work engagement with a father accused of abuse.	Respectful dialogue, cooperative intervention	Exemplifies non-adversarial, rights-respecting practice central to Bairns' Hoose ethos.	Collaborative engagement achieved safety and behaviour change without escalation.	Respectful, relational practice supports accountability and trust.
Gagné et al., 2023	Canada	Family violence toward children (psychological aggression; minor physical violence)	Triple P (Levels 3-4) structured individual and group parenting intervention.	CBT, social learning, structured parenting	Preventative, non-punitive, child-centred parenting support; integrates well within early intervention tiers.	Triple P improved parenting; reduced minor violence; effects sustained long-term.	Relationship quality and intervention intensity matter; limited effect on psychological aggression.
Herschell et al., 2020	USA	Risk of physical abuse (harsh discipline, family conflict) plus exposure to domestic/emotional violence	Treatment-as-Usual in community mental health centres, often inconsistent and low-intensity CBT components.	Mixed, low-intensity therapy elements	Partial alignment; lacks consistency and integration expected from Bairns' Hoose model.	TAU lacked structure and EBT depth; high dropout.	TAU contains EBT elements but too low intensity for strong outcomes.
Jouriles et al., 2010	USA	Physical abuse and neglect (substantiated maltreatment)	Project Support: home-based parenting skills and social/instrumental support.	Home-based parenting training and social support	Intensively child-centred, relational and supportive; strong alignment with multi-agency family recovery models.	Large reductions in harsh parenting and CPS re-referrals; high resource demands.	In-home behavioural support effective but resource-intensive.

Study (Author, Year)	Country	Type of Harm (Physical abuse, violence, assault, weapon use)	Intervention Description and Approach	Approach	Relevance to Bairns' Hoose Principles	Outcomes (Short Summary)	Notes (Short Practitioner Insights)
Kjellgren et al., 2013	Sweden	Physical abuse (hitting, smacking, objects, strangling, confinement) and exposure to domestic violence	Combined Parent–Child Cognitive-Behavioural Therapy (CPC-CBT).	Psychoeducation, MI, safety planning, anger management	Trauma-informed, family-inclusive therapy aligned with Bairns' Hoose principles.	Reductions in parental depression, corporal punishment, and child trauma symptoms.	Integrated parent-child models feasible with cultural adaptation.
Lanier et al., 2018	USA	Physical abuse and neglect (no sexual abuse)	Pathways Triple P, home-delivered structured parenting.	Home-delivered parenting support	Enhances child wellbeing and caregiver capacity; supports trauma reduction and positive relationships.	Improved child quality of life; strong engagement; minor reporting discrepancies.	Validates Pathways Triple P for CWS; parent-mediated gains important.
MacMillan et al., 2005	Canada	Physical abuse and neglect (sexual abuse excluded)	Nurse-delivered home visitation for two years focusing on parent support and family functioning.	Ecological, intensive home visiting	Indirectly aligns with prevention, early intervention, and safeguarding.	No significant reduction in recurrence; possible surveillance bias.	Nurse training strong; challenges in engagement and recruitment.
MacMillan et al., 2009	Primarily high-income countries: USA, Canada, UK, Australia, New Zealand, Western Europe (studies reviewed).	Physical abuse, emotional abuse/neglect, and sexual abuse (varied across interventions)	Review of home visiting, parenting programmes, community and school interventions.	Multi-modal prevention and treatment	Reinforces principles of early support, trauma-informed practice, and integrated systems.	Home-visiting and structured parenting programmes show best evidence.	Fidelity and service integration are key for lasting effects.
Mast et al., 2014	USA	Physical abuse – abusive head trauma (AHT)	Web-based I-INTERACT parenting intervention with live coaching.	Online coaching, behavioural parent training	Child-centred and trauma-informed; enhances positive interactions and reduces harm.	Improved parenting; fewer behaviour problems; web delivery feasible.	Remote coaching supports skill development and lowers barriers.
Nabors et al., 2016	USA	Trauma exposure including physical abuse, sexual abuse, and witnessing violence	Community counselling with play and art-based trauma interventions.	Non-directive, expressive trauma therapy	Child-centred, safe therapeutic spaces fostering emotional regulation and resilience.	Qualitative improvements in emotional regulation and coping; no quantitative data.	Play and art crucial for trauma expression in younger children.

Study (Author, Year)	Country	Type of Harm (Physical abuse, violence, assault, weapon use)	Intervention Description and Approach	Approach	Relevance to Bairns' Hoose Principles	Outcomes (Short Summary)	Notes (Short Practitioner Insights)
Ray et al., 2017	USA	Physical abuse and sexual abuse (majority sexual; some physical)	Bikers Against Child Abuse: community-based safety and support intervention.	Community support, advocacy, emotional safety	Supports empowerment, emotional safety and advocacy.	Improved emotional and behavioural functioning; no major challenges.	Community-based support enhances safety and empowerment.
Runyon et al., 2009	USA	Physical abuse/excessive physical punishment; some domestic or sexual violence exposure	CPC-CBT group model combining parent and child therapy.	Trauma narrative, parenting skills, joint sessions	Trauma-informed, relational, behavioural; promotes family safety and communication.	Large reductions in PTSD and externalising behaviours; better parenting; small sample.	Joint parent-child CBT vital for relational repair.
Runyon et al., 2010	USA	Physical abuse (hitting, beating, shaking, slapping, object use)	CPC-CBT versus Parent-Only CBT.	CBT-focused trauma and parenting work	Strong alignment with child participation and recovery-focused work.	CPC-CBT improved PTSD symptoms and positive parenting; sustained gains.	Including children strengthens trauma recovery and safety.
Schaeffer et al., 2013	USA	Physical abuse and neglect (with some emotional abuse)	MST-BSF: integrated multisystemic therapy for substance-using, maltreating families.	Integrated substance use and maltreatment treatment	Emphasises child safety, family change and multi-system engagement.	MST-BSF reduced reabuse, substance use, and child anxiety.	Intensive, home-based, integrated model supports both parent and child.
Scott & Lishak, 2012	Canada	Child maltreatment: physical abuse, neglect, and exposure to domestic violence	Caring Dads 17-week programme for maltreating fathers.	Anger management, parenting skills, case management	Focuses on child safety, parenting change and co-ordinated risk-management.	Improved parenting and co-parenting; small effects on aggression.	Father-focused work viable and improves relational dynamics.
Selvapandiyan et al., 2018	India	Physical abuse and attempted strangulation (trauma leading to PTSD)	Imagery-based cognitive therapy using play, role-play, drawings and coping imagery.	Play techniques and imagery	Child-centred therapeutic work that complements Bairns' Hoose principles, although not multi-agency.	Large PTSD reduction in single case; sustained improvements.	Developmentally tailored imagery therapy effective for single-incident trauma.
Silovsky et al., 2011	USA	Risk of physical abuse/neglect with exposure to IPV and caregiver substance/mental health issues	SafeCare+ augmented with motivational interviewing for high-risk rural families.	Skills-based home visiting with MI	Child-centred, skills-focused, community-aligned intervention.	Improved satisfaction, skills, and DV reports; limited power for recidivism effects.	Local provider knowledge essential in rural contexts.
Swenson et al., 2010	USA	Physical abuse (CPS-referred youth)	MST-CAN: intensive multi-system treatment for child abuse and neglect.	Intensive multisystemic therapy	Strong alignment: child-centred, trauma-informed and collaborative.	MST-CAN improved parenting, mental health, and reduced placements.	Model works well in community settings with broad support.
Thulin & Kjellgren, 2017	Sweden	Physical abuse by caregivers (co-occurring emotional abuse/neglect; multiple traumas)	Swedish CPC-CBT (KIBB) delivered in Barnahus context.	CBT-based structured family therapy	Directly aligned with Bairns' Hoose, emphasising safety, trauma recovery and multi-agency co-ordination.	Reductions in trauma symptoms and harsh parenting; cultural adaptation needed.	Barnahus model supports early, collaborative intervention.

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Thulin et al., 2019	Sweden	Physical abuse by caregivers (confirmed, often long-term with emotional harm)	CPC-CBT from children's perspectives; 4-phase model.	Four-phase structured trauma-focused therapy	Embodies child participation, trauma reduction, and inter-agency collaboration.	Children reported safer homes, better communication, and cessation of violence.	Trauma letters and child inclusion seen as transformative.
Thulin et al., 2020	Sweden	Physical abuse (spanking, choking, kicking, pushing; object use) with emotional-verbal abuse	CPC-CBT outcomes for psychosocial wellbeing and parenting.	Engagement, coping, safety planning	Reinforces child-centred recovery, relational healing and safety planning.	Large reductions in corporal punishment and trauma; maintained at follow-up.	Children value being heard; CPC-CBT feasible across services.
Webb et al., 2017	Australia	Risk of child maltreatment (including physical abuse) in high-risk families	PCIT with and without motivational enhancement.	Parenting skills and motivational enhancement	Supports parent-child engagement, relational safety and behaviour change.	Motivational enhancement reduced PCIT attrition modestly.	ME helpful for some parents; PCIT still demanding for many.
Wegman & O'Banion 2012	USA	Physical abuse and emotional/psychological abuse	Educational and school-based trauma-informed support for students affected by abuse.	School-embedded, child-centred, trauma-informed practice.	Promotes safety, understanding and non-punitive responses; supports trauma-aware school environments aligned with child-centred care.	<i>No empirical intervention outcomes.</i> Chapter describes impacts of physical and emotional abuse on students, with emphasis on trauma-related behaviour in school settings. Highlights common misinterpretations of trauma symptoms as misconduct. Challenges / Unintended Consequences: School implementation barriers (staff training limits, resources, stigma, difficulty distinguishing trauma from behavioural issues).	Provides vignettes illustrating shifts from punitive responses to trauma-informed approaches. Emphasises that educator understanding of trauma reduces mislabelling, promotes supportive discipline, and improves school climate.

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Weiler & Taussig 2019	USA	Broad maltreatment including physical abuse, sexual abuse, neglect, and violence exposure	Fostering Healthy Futures: 9-month mentoring + skills groups for maltreated children in foster care.	Relational, strengths-based mentoring; coping skills, resilience-building.	Supports emotional safety, stable relationships and prevention of re-traumatisation; highlights need for tailored support for high-risk children.	Children with low–moderate ACE risk improved in PTSD and dissociation; high ACE exposure showed no improvement vs controls. Other mental-health, coping, self-worth, and social-support measures assessed, with strongest effects on trauma outcomes.	High-risk children may need additional/modified interventions; highlights importance of risk stratification. Shows risk of “one-size-fits-all” models and importance of identifying subgroups who benefit most.
Zajac, Randall & Swenson. 2015	USA	Physical abuse/neglect alongside externalising behaviour and offending (MST-CAN samples)	Multisystemic Therapy (MST) and MST-CAN for families experiencing abuse/neglect.	Intensive, home-based, multisystemic intervention; problem-solving, family strengthening.	Holistic, family-centred and multi-agency; aligns with integrated safeguarding pathways and trauma-informed systems.	MST effective for reducing delinquency, recidivism, substance misuse, externalising behaviour. MST-CAN linked to reductions in abuse/neglect and improved family outcomes. Review summarises implementation, fidelity, and adaptation insights.	Strong emphasis on adapting MST specifically for maltreatment cases (MST-CAN), not simply transferring juvenile-justice MST. Highlights systemic approach, family empowerment, flexibility, and outreach across systems.