



Action for Children  
Child Outcomes-Focused Evaluation  
Final Data Collection Report

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# Action for Children Child Outcomes-Focused Evaluation

## Final Data Collection Report

### Introduction

This outcomes evaluation forms part of a multi-component evaluation commissioned at Canterbury Christ Church University (CCCU) by Action for Children. The aim was to evaluate the work of a UK network of eight intervention projects (known as 'Safe and Secure') for children and young people, who have experienced the trauma of sexual abuse. These projects offer direct services to children and families in the aftermath of child sexual abuse through a variety of different approaches to therapeutic support.

Other parts of the evaluation have been reported separately<sup>1</sup>. This report presents both the child outcomes-focused evaluation and the qualitative collection of children's views. The outcomes focused evaluation presents the findings from a comparative analysis of the baseline data gathered at the pre-intervention stage between May and October 2008 and that gathered post-intervention between July 2008 and November 2009 with particular reference to changes and outcomes for the children involved. In contrast to the purposes of the baseline data collection report, this final report aims to provide a comparison between the baseline data collection stage (pre-intervention) and the follow-up 12 month data collection stage (post-intervention). For that reason, the presentation of the research findings in this report differs from the baseline report. Correlations between different outcome variables will not be reported here. Instead the major focus will be on evaluating the changes in children/young people's outcomes since the baseline data were collected.

### Aims

The overall evaluation has the following aims, with bullet points 3, 5, 6, and 7 being addressed directly or indirectly by the data included in this report:

- Developing a strategic overview of child sexual abuse projects.
- Evaluating working practices.
- Providing empirical evidence of outcomes for children/young people who have received child sexual abuse support services.
- Providing evidence of the need for and the impact of child sexual abuse support services.
- Supporting the need for early intervention and the increase in therapeutic support services to children who have been abused.

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<sup>1</sup> The current report can be read independently of the other parts of the evaluation. The meta review is available from the Action for Children website. Both that and the baseline report are also available from the lead investigator, Esther Coren ([esther.coren@canterbury.ac.uk](mailto:esther.coren@canterbury.ac.uk)).

- Supporting capacity building within Action for Children and contributing to the planning and provision of additional child sexual abuse services across the UK.
- Supporting the negotiations with statutory partner agencies towards the development of additional services.
- Providing a robust monitoring mechanism by which the service can review and evaluate progress.
- Taking account of and working in harmony with other appropriate service providers.

### Specific aims of this element of the evaluation

The aim of this element of the evaluation was to investigate outcomes of the interventions for individual children and young people attending Action for Children projects in the 'Safe and Secure' Network. Whilst the remit of some projects extends to areas of work broader than child sexual abuse, the purpose of this evaluation is to assess the outcomes for children and young people who have been affected by sexual abuse and who have received professional support to promote their recovery from that experience from Action for Children. This report presents analyses that compare the data collected during the baseline assessment with those collected during the 12 month follow-up assessment and includes a qualitative evaluation of the children's/young people's views, featuring an activity book. The current report will therefore specifically detail the follow-up phase of data collection and the changes in children's/young people's outcomes as assessed during the follow-up.

### Background

Estimates of the prevalence of child sexual abuse in the UK range from 3% to 36% for females and from 3% to 29% for males, depending on the definition used, methods of sampling and data collection adopted (Cawson, Wattman, Brooker & Kelly, 2000). For the year ending March 2008, 2200 children in England were the subjects of a Child Protection Plan (CPP) under the category of sexual abuse (DCSF, 2008). In Wales, 160 sexually abused children were on the child protection register for being subjects of a CPP in the year ending 2008, with a further 45 children on the Welsh child protection register in the category of sexual abuse together with neglect and/or physical abuse (Local Government Data Unit Wales, 2008). Children become the subject of a CPP if - following a child protection conference - they are considered to be at risk of continuing harm (DfES, 2006). More recently, the NSPCC (National Society for the Prevention of Cruelty to Children) published police data, reporting 21,618 reported sex offences against children from April 2008-March 2009 across 43 police forces in England and Wales (NSPCC, 2010).

Children and young people react to child sexual abuse in a variety of ways including in some, behavioural and psychological problems both for those who experience the abuse directly as well as those indirectly affected by it (e.g., other family members; Carter, 1993). Such problems can affect children and young people in the short term, but also in later adult life (Putnam, 2003). Sometimes, child sexual abuse has been associated with sexualised behaviour (e.g.,

McClellan et al, 1996) although by no means all survivors manifest this, and also symptoms of Post Traumatic Stress Disorder (PTSD; e.g., Deblinger, Lippman & Steer, 1996; Paolucci, Genius & Violato, 2001). Links have also been made, in some survivors, with compromised psychological functioning (e.g. Fergusson, Horwood & Lynskey, 1996; Read, 1997), depression and low self-esteem (Mullen, Martin, Anderson, Romans, & Herbison, 1996), eating disorders (Wonderlich, Brewerton, Jovic, Dansky, & Abbott, 1997), suicide (Paolucci et al., 2001) and substance misuse (Arellano, 1996). Interventions reported in the literature seem to have most commonly targeted fear, anxiety, low mood and sexually inappropriate behaviour (MacDonald, Higgins & Ramchandani, 2006; Kendall-Tackett, Williams & Finkelhor, 1993). Kendall-Tackett et al. (1993) suggest that there is a lack of evidence to support one obvious response by children who have been sexually abused. In fact, many abused children display a variety of problems with no single response being displayed by a majority (Kendall-Tackett et al., 1993). Of course, the issues listed above are not only associated with sexual abuse, and many young people displaying these behaviours may not have been abused (e.g., Capps, Sigman, Sena, Henker & Whalen, 2006).

This having been said, significant numbers of children survive child sexual abuse without appearing to experience adverse psychological consequences (Dominguez, Nelka & Perry, 2006; Taylor, 2002). It is possible that these children might be affected differently than others, but also that in some survivors the consequences of abuse may only become apparent later (see Briere & Elliott, 1994). Child sexual abuse has been linked to an increased risk of a variety of psychological problems in adulthood (Jumper, 1995). However, it is also true that children differ from one another and do not form one homogeneous group; for example in terms of age and stage of development. These factors may play a part in determining the recovery of children following experience of trauma, including that of child sexual abuse (Bolger & Patterson, 2001). Rutter (1999) suggests that multiple risk and protective or resilience factors are significant in children's recovery from trauma with considerable variation in baseline vulnerability to psychosocial stress, related to various genetic and environmental factors.

A variety of interventions exist to promote recovery from trauma following child sexual abuse (e.g., Hetzel-Riggan, Brausch & Montgomery, 2007). These interventions differ in their theoretical bases as well as their structure and content. Coren and Hutchfield (2009a) conducted a meta-review (as part of this evaluation for Action for Children), which reviewed findings from 5 reviews of child sexual abuse interventions. This review concluded that from the data reviewed (62 studies included in 5 reviews) robust evidence is supportive of the use of cognitive-behavioural therapy (CBT) with some evidence from less rigorous research appearing to support the use of other therapies, such as psychodynamic and humanistic approaches (e.g., Skowron & Reinemann, 2005). Furthermore, the meta-review authors concluded that the importance of moderator variables (e.g., treatment and client characteristics), which may have an impact on treatment outcomes, should be investigated in future research. For this reason, a tailor-made focussed approach for each child or young person appears to be preferable, which should ideally be accompanied by a supportive and positive therapeutic relationship between the client and the therapist. Moreover, the meta-review authors stress the importance of methodologically sound evaluation studies and a closer collaboration between practitioners and researchers.

This last issue was particularly apparent from the meta-review. Early in the evaluation, researchers and Action for Children project staff collaborated in defining outcomes to be assessed in the evaluation as discussed later in this report. Of these, referrals to other agencies, self-harm, decreased medication, more secure residential placements, school attendance and bedwetting were not included as outcomes in the reviews evaluated in the meta-review. Of those that were included, outcomes were not always expressed in the same way as expressed by practitioners. This experience led researchers to the conclusion that a closer collaboration between researchers and practitioners would enable research to be more practice relevant (Coren & Hutchfield, 2009a).

## Methods

### Participants

An anonymised sample of 86 children and young people across eight Action for Children projects in the 'Safe and Secure' Network was included in the baseline stage of the child outcomes-focused data collection. The eligibility criteria for inclusion in the evaluation were outlined in the Action for Children outcomes-focused evaluation baseline data collection report (Coren & Hutchfield, 2009b). In the baseline report, the baseline behavioural data for 52 cases were presented. These are the cases (of the original 86), which were offered and received a service from participating projects.

Of the initial 52 cases with behavioural data, ten cases were closed with no follow-up data provided. For that reason, these cases were not included in the current analyses. The remaining 42 cases can be broken down into 30 closed cases for which follow-up behavioural data were collected and twelve cases which are still open and which also provide behavioural data. Project staff were consulted about the suitability of children/young people for inclusion in the qualitative element of the evaluation (activity books<sup>2</sup>), taking into account the child/young person's ability to complete the task, their current stage in therapy and their perceived vulnerability. Children/young people under the age of 6 years were excluded from the qualitative element as they were likely to be developmentally unable to complete the task independently. Young people over the age of 18 years would also have been excluded from this element as they are adults, but in the event there were no participants in this category. Only three children were included in this part of the evaluation, two girls and one boy, so the findings from this element are purely illustrative.

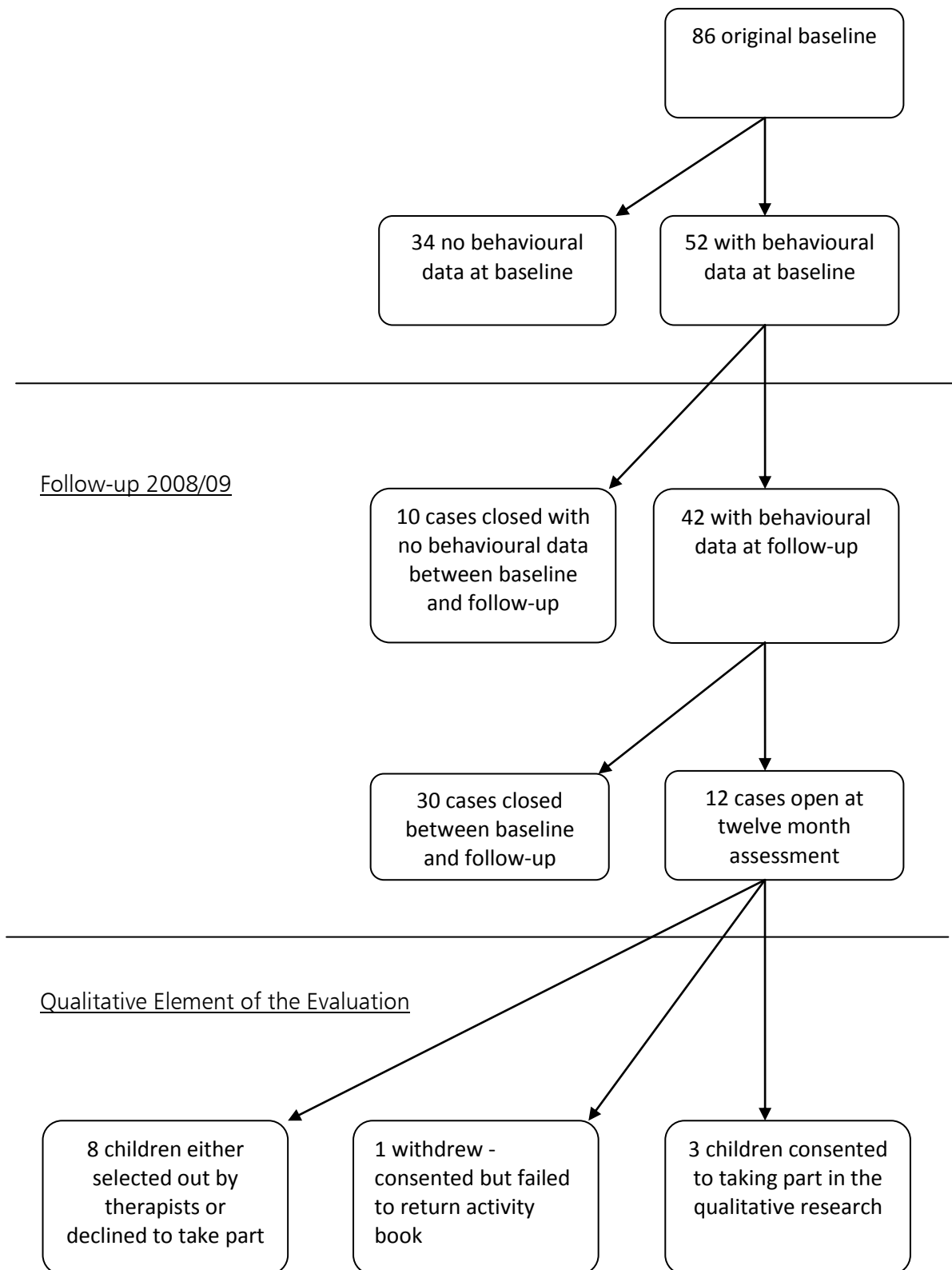
The breakdown of cases included at the 12-month follow-up data collection and the qualitative element of the evaluation can be seen in Figure 1.

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<sup>2</sup> For a more detailed description of the activity books, please see pages 10 & 11 of this report.

Figure 1: Breakdown of cases for baseline & follow-up (including qualitative evaluation)

Baseline Data in 2008



As demographic information was available for all remaining 42 cases from the baseline data, demographic details were not collected again at the follow-up stage. Consequently, all demographic details of the cases included in this final report is based on data collected for the baseline report. Furthermore, as some of the cases were closed before the 12-month follow-up but data on age were not collected again, we cannot infer that the cases involved in the evaluation are exactly one year older than at the baseline data collection date, particularly as, for reasons of confidentiality, we have information on ages rather than dates of birth. For that reason, we are unable to make exact claims about the age distribution of the children and young people involved in the analyses for this final report. However, the children and young people should be up to one year older than they were at baseline data collection, the average (mean) age of which was 12.75 (SD = 3.28), ranging between four and 18 years of age at the time of the baseline assessment (these numbers refer only to the 42 cases included in this final report).

The sample of 42 children/young people for whom follow-up data are available consisted of 13 males (31%) and 29 females (69%). Twelve children/young people (29%) were recorded as having some form of disability, with the largest proportion reported as having a learning disability (24%) (Self or parent reported). Thirty-seven children/young people (88%) were indicated to be of White British origin (self or parent reported). One child/young person (2%) was indicated to be of Black British origin, one child/young person (2%) was reported to be of mixed ethnic origin, two children (5%) were recorded in the "Other" category and ethnicity was not given for one child/young person (2%).

## Measures

During the initial stages of the outcome evaluation, outcomes of interest for service users and providers were discussed and agreed in collaboration with Action for Children staff. One important aspect in these decisions was the need for the outcomes to be measurable. The following list gives an overview of all the outcomes which were included in this element of the evaluation:

- Sexualised behaviour
- Violent/aggressive behaviour
- Self harm behaviour
- Anger/flashbacks/nightmares/bedwetting
- Attendance of appropriate educational provision/employment
- Referrals to other agencies
- Residential placements
- Mental health symptoms and emotional well-being
- Social relationships
- Emotions and feelings
- Experience and feelings of blame, guilt, shame and stigma.

As outlined in the baseline report (Coren & Hutchfield, 2009b), a baseline referral data form was initially designed to standardise the collection of data on the relevant outcome variables (see Appendix 1). In order to assess changes in the children and young people's strengths and difficulties scores between the time of initial referral and 12 months later/when the case was closed, the Strengths and Difficulties Questionnaire (SDQ) by Goodman (1997) was administered at both time points. The SDQ is a short behavioural screening tool for 3 to 16-year olds and exists in several different versions. One version of the SDQ can be administered by parents or teachers of 4 to 16 year old children and young people. Furthermore, there is a self-completion version of the SDQ for adolescents (Goodman, Meltzer & Bailey, 1998), which asks for the same 25 traits, however, its wording is amended for self-completion.

All versions of the SDQ consist of 25 items, which belong to five subscales relating to positive and negative psychological attributes. These five subscales are: emotional symptoms (five items), conduct problems (five items), hyperactivity/inattention (five items), peer relationship problems (five items) and prosocial behaviour (five items). For the purpose of the present research, the relevant follow-up versions of the SDQ were used including the SDQ impact supplement (Goodman, 1999). These include the 25 basic items and the impact question. The parent-completion and self-completion follow-up versions of the SDQ can be found in Appendix 2.

In line with the procedure used for the baseline data collection, the SDQ was also used for young people older than 16 years. This was in order to ensure the consistency of data collection and to enable researchers to compare outcomes across the full sample. However, it is important to note that the SDQ is not actually validated for use with this age group (see Goodman et al., 1998).

## Design

The quantitative element of the present evaluation (questionnaires) features a single group longitudinal pre-test – post-test design, chosen to allow for an assessment of the change in behaviour as well as emotional problems in children and young people following child sexual abuse. Due to ethical considerations as well as restrictions in time and resources, it was not possible to compare the outcomes of more than one group within the scope of this evaluation. This methodological constraint is discussed further in the strengths and limitations section of this report.

The qualitative element of the present evaluation (activity books) utilises a cross-sectional design, using a specifically designed qualitative activity book. The results were analysed using categorisation of open-ended responses and thematic analysis. In the results section for this part of the evaluation we group responses under outcomes identified by Action for Children project staff as important for children and young people recovering from sexual abuse.

This final report presents data from children and young people who were offered treatment and either completed or are still undergoing treatment. In contrast to the initial planning of this evaluation, there will be no 24-month follow-up as the number of children/young people ( $n = 12$ ), who are still receiving treatment, is too low to conduct meaningful statistical analyses.

## Procedure

The procedures for piloting the referral point data form and the training of project staff have been outlined in the baseline report (Coren and Hutchfield, 2009b). The data collection for the follow-up took place between the end of July 2008 and late October 2009. This data collection timeframe is rather wide because some of the cases closed quite quickly (within one month), whereas some cases were followed up at the planned 12 month assessment and further cases closed and were followed up even later (after more than 15 months).

Similarly to the distribution of the baseline materials, each project received electronic and paper copies of the follow-up materials pack. The project staff was asked to include the random number for each child/young person being followed-up in order to ensure that the data from baseline could be matched with data from the follow-up. The follow-up assessment forms are available in Appendices 1 and 2. The project manager or a member of therapeutic staff completed the follow-up form and the SDQ either once a case closed or at 12 months after the first assessment meeting. Where possible, the SDQ was completed by the parent or carer of the child/young person – either personally or by telephone. In eleven cases a self-completion version of the SDQ (Goodman et al., 1998) was given to the young person to complete. All completed forms were returned to the researchers at CCCU via confidential mail.

As was the case with the baseline data, data from the follow-up forms were entered into a statistical software package (SPSS Version 16) for analysis. The original forms are kept in a locked filing cabinet and the SPSS data file with the children and young people's raw data are stored on computers with passwords known only to the CCCU research team staff.

Recruitment for the qualitative part of the evaluation (activity books) was generated from the pool of children included in the longitudinal evaluation. Children/young people were randomly selected, stratified by project (max of 4 from each project). Children/young people included were given a sealed pack by project staff which contained all data collection materials (including activity book, covering letter, information sheet and envelope) identifiable by the inclusion of their participant number on the front page. Therapists introduced and explained to children/young people and their parents/carers the use of the activity book, and children/young people were given a week to decide if they would like to take part. Those who agreed signed a consent form and were given a week to complete their activity book, preferably at home, or at the project if this was more appropriate. Activity books were returned in a sealed envelope to the project. The project then forwarded these sealed envelopes to Canterbury Christ Church University.

The completed questionnaires and activity books will be retained until after the evaluation is completed. Once all data have been analysed and the findings are disseminated, the paper forms with the data will be confidentially and securely destroyed. In the case of the activity books, children were offered to have these back after the research was completed. No requests were made.

## Ethical Considerations

This final report forms part of a commissioned evaluation conducted on behalf of Action for Children. Throughout the data collection stages, all data were supplied by projects in an anonymised state to the research team. CCCU research team staff then aggregated these data and analysed them on behalf of Action for Children using data collected by projects at referral/initial assessment. All data collection was undertaken by projects in the course of the routine data gathering.

The evaluation has been conducted according to Action for Children's own ethical guidelines and to support this, a steering group that includes senior managers and policy staff from the organisation played a key role in project management. There was no direct contact between participants and their families and the research team. On this basis the University Ethics checklist was completed at the time of project start and submitted to the Faculty Ethics Committee.

When a subsequent element of the evaluation was considered in detail by this ethics committee, questions were asked about whether children themselves were to be included in the audit, or merely data about the children and young people. The latter was considered to be satisfactory and no further approval was suggested.

Consent was obtained from all children/young people prior to being included in the qualitative element of the evaluation. Where children/young people were aged less than 16 years, had a learning disability or were considered by their therapist to be particularly vulnerable, consent was also obtained from a parent/carer. Consent forms were kept by the Action for Children projects and project managers signed a form to confirm the participant numbers of those who gave informed consent. Staff from the Action for Children projects did not see the activity books once the children/young people had begun completing them.

The qualitative element of the evaluation received ethical approval from the Faculty Research Ethics Committee, the UK National Association of Directors of Children's Services (ADCS), and also by Children's Services Directors/research approval groups in the relevant areas.

## Results

### A guide to the results

Follow-up data were collected on 42 cases across eight Action for Children projects in the 'Safe and Secure' Network. Of these 42 cases, behavioural outcomes data are available for between 26 and 41 cases depending on the variable, as in some cases not all sections of the follow-up form were completed. It may be that some questions were not completed in all cases due to the sensitivity of the question focus. For example, one therapist reported feeling uncomfortable asking questions about bedwetting.

All children/young people included in this follow-up evaluation received treatment from projects in the Safe and Secure Network. As is evident from the general evaluation report submitted to Action for Children in March 2009 (Coren & Hutchfield, 2009c), in most cases, Action for Children projects providing services for families affected by sexual abuse are oversubscribed and have waiting lists for service provision. As such, the service can be seen as a relatively scarce resource. This finding has recently been reported in the UK National press (Action for Children, 2009; <http://www.guardian.co.uk/action-for-children/survive-and-thrive>). This scarcity has been further corroborated by a national mapping exercise conducted in the UK by the NSPCC (Allnock, Bunting, Price, Morgan-Klein, Ellis, Radford & Stafford, 2009)

In such an environment, referrers (mostly Social Services Departments) are likely to refer the most serious cases. This is borne out by the complex interaction of needs presented by the children and young people who attend the projects and who are represented in the evaluation. These reports therefore cannot be seen as representing a description of all children and young people affected by sexual abuse, rather a subset of such children and young people who are referred for specialist services and are offered and remain in continued treatment. Thus, the sample on which this report is based is a very specific and self-selected sample which may impact the generalisability of the findings (see also Juster, Heimberg & Engelberg, 1995).

Basic descriptive statistics were computed for demographic and behavioural outcomes. In the case of behavioural outcomes, statistics only refer to the portion of the sample for which data are available i.e., those children and young people who received a service and for whom data were available for follow-up. The included sample sizes ranged from 26 to 41 included children/young people. T-tests, Chi-square tests and McNemar tests (explained overleaf) were computed as appropriate for behavioural variables in order to establish whether the children/young people's outcomes have changed since the baseline assessment. The actual sample sizes for each outcome variable are included in brackets next to the outcome variable heading.

For all statistical calculations, raw data from the baseline referral form and the follow-up form have been analysed. For the SDQ, data from the 25 item scale were first transformed into six new variables, according to a standardised procedure: one giving a total score for each of the five subscales of the SDQ (emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship, prosocial behaviour) and one giving a Total Difficulties Score aggregating data

from the first four of these subscales. The content of each of the subscales can be seen in Appendix 3.

The analyses presented in this report include two different types of variables: continuous and categorical variables. According to Gravetter and Wallnau (2009), a continuous variable is a variable for which there is an infinite number of possible values that fall between any two observed values. In our report, we treated all data collected using the SDQ as continuous data. In contrast, according to Sheskin (2000), categorical data represent mutually exclusive categories. In this report, categorical data were used for the assessment of the presence versus absence of certain behaviours such as aggressive or sexually inappropriate behaviours. If there are only two categories within a categorical variable (such as aggressive behaviour present versus absent), one can also speak of a dichotomous (or binary) variable.

Although SDQ scores can be presented as continuous variables, sometimes classification is useful. SDQ scores are categorised according to 'normal', 'borderline' and 'abnormal' bands. SDQ bandings have been chosen so that roughly 80% of children in the community are classified as normal, 10 % are borderline and 10 % are abnormal (Goodman, 1997). Authors of the scale acknowledge this as a 'rough and ready' method for detecting disorders. SDQ bandings can be found in Appendix 2.

Where **correlations** are reported in the text below, 'r' is the correlation coefficient and the *p* value indicates the statistical significance of the correlation. The sign (+/-) of the correlation coefficient represents the direction of the correlation. A positive correlation between two variables indicates that an increase on the scale of one variable is related to an increase on the scale of the second variable. This does not indicate that an increase in one variable *causes* an increase in the other variable. A negative correlation between two variables indicates that an increase on the scale of one variable is related to a decrease on the scale of the second variable. Again, this does not imply causation. The correlation coefficient represents the strength of the correlation. Correlations are interpreted according to Cohen's guidelines, see Table 1 below:

**Table 1. Cohen's (1988) Guidelines for Small, Medium and Large Correlation Coefficients**

Correlation	Negative	Positive
Small	-.29 to -.10	.10 to .29
Medium	-.49 to -.30	.30 to .49
Large	-1.00 to -.50	.50 to 1.00

Correlations are deemed statistically significant if they have a *p* value of less than 0.05. Those with a *p* value of less than 0.01 are considered to be highly statistically significant. Correlations are fully interpreted within the text.

Where **chi square tests** are reported in the text below, ' $\chi^2$ ' is the chi-square statistic and the  $p$  value indicates the statistical significance of the test. As with correlations, a chi-square test is deemed statistically significant if it has a  $p$  value of less than 0.05. Those with a  $p$  value of less than 0.01 are considered to be highly statistically significant. Where a chi-squared test is statistically significant this indicates that there is a statistically significant relationship (more than just chance) between two variables. Examination of the frequencies for each variable can inform interpretation of the nature of this relationship. Chi-squared tests are fully interpreted within the text.

The **McNemar test** (McNemar, 1947) is a statistical procedure for categorical data. It is employed to evaluate a one-group pre-test-post-test design (see Sheskin, 2000). Following the baseline assessment, all children/young people included in this final report were exposed to treatment, after which the researchers from CCCU analysed the follow-up forms on the same dichotomous variables. The McNemar test evaluates whether there is a significant difference between the pre- and post-test scores of the children/young people on the outcome variables such as sexually inappropriate behaviour, aggressive behaviour or self-harming behaviour. As with the previous tests, a  $p$  value of less than 0.05 is considered statistically significant and a  $p$  value of less than 0.01 is considered as highly statistically significant. The results of all McNemar tests are fully explained within the text.

**Paired-samples t-tests**<sup>3</sup> were used in order to assess whether there is a systematic difference between the children's/young people's outcome scores for the follow-up assessment as compared to the baseline assessment (see Gravetter & Wallnau, 2009). However, in contrast to the McNemar tests, paired samples t-tests are applied for continuous outcome variables. This was the case for the assessment of changes in – for example – the number of nights with undisturbed sleep, the percentage of time spent in appropriate education and all SDQ scales. Again, a  $p$ -value of less than 0.05 indicates statistically significant mean differences between the baseline and the follow-up assessment. These differences can be considered highly statistically significant if the  $p$ -value is smaller than 0.01. However, the interpretation of all results requires some caution as with one-group repeated measures designs it is possible that time-related factors other than the intervention can cause differences in participant's outcome scores (Gravetter & Wallnau, 2009).

**Independent samples t-tests**<sup>4</sup> were used for the assessment of mean differences for continuous variables between two separate samples, such as gender differences in hyperactivity scores.

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<sup>3</sup> The CCCU research team discussed whether a Wilcoxon Signed-Ranks Test should be applied in some instances instead of the paired-samples t-tests. This was due to the fact that in some instances the statistical assumptions of the t-test might be violated. However, for reasons of consistency, we decided to continue using t-tests. In order to ensure the quality of the results presented here, we run Wilcoxon Signed-Ranks Test on the relevant outcome variables. The results of these analyses did not differ from the t-test results presented in this report.

<sup>4</sup> The CCCU research team discussed whether a Mann-Whitney U Test should be used in some instances instead of the independent samples t-tests. This was due to the same reasons as stated in footnote <sup>3</sup> above. Again, the team decided to continue using t-tests, especially as the results given by the Mann-Whitney U Tests did not differ from the results presented in this report.

These tests are used to compare the sample means for a relevant outcome variable. A  $p$ -value of less than 0.05 indicates a statistically significant result. Differences between groups can be considered highly statistically significant if the  $p$ -value is less than 0.01. Subsequent inspection of the mean scores of the two assessed groups (e.g., boys and girls) can then be used in order to determine the direction of this statistical effect. The results of all independent samples t-tests are fully explained in the text.

All relevant results are reported under outcome headings as agreed with Action for Children staff during the development of the evaluation. It should be noted that throughout the results, reference is made as to whether results are significant or not. This always refers to statistical significance, which is essentially a calculation as to the probability that the results could be due to chance. It would be inappropriate to infer that any non-statistically significant results are not important. Statistically non significant results might be very important in the lives of the service users concerned.

## Child Outcomes evaluation results: 12 month quantitative follow-up (questionnaires)

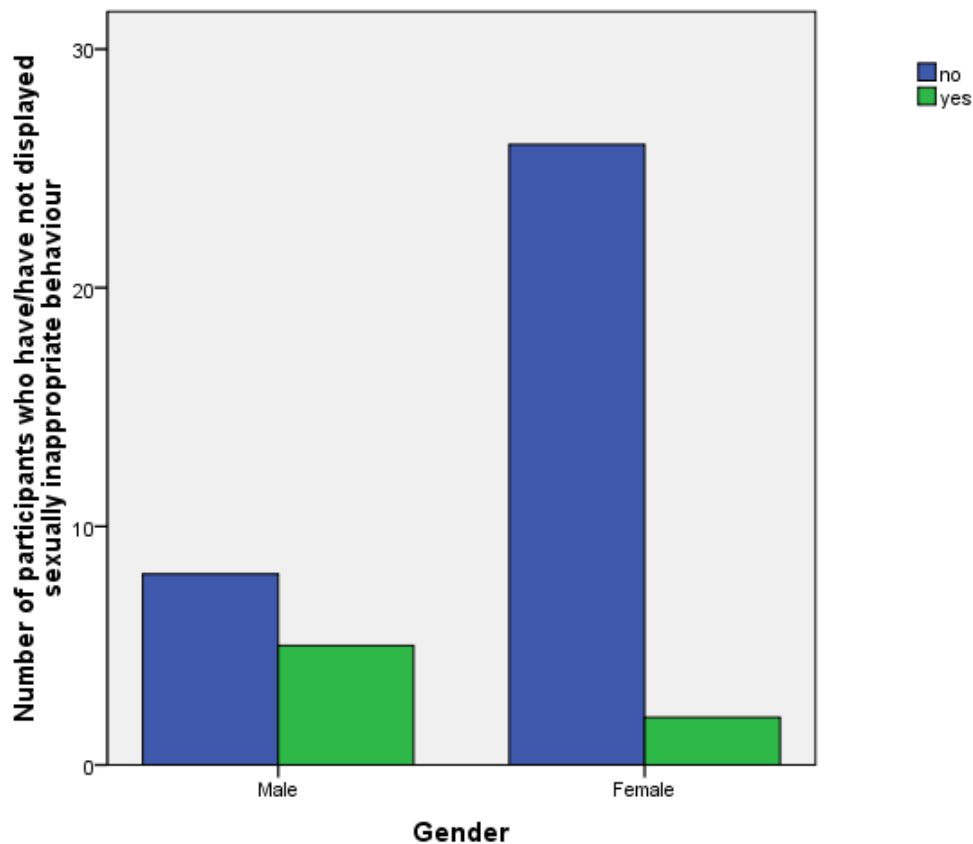
The following outcomes relate to the data collected using the child outcomes evaluation follow-up form (questionnaires). Wherever possible and appropriate, the data collected at follow-up will be compared to the data collected at baseline. Each section first presents the data for the follow-up before presenting the comparison.

### Sexually inappropriate behaviours (n = 41)

Seven out of 41 (17%) children and young people were reported to have exhibited sexually inappropriate behaviours at the time of the follow-up assessment. Three (7%) of these children and young people were reported to have exhibited sexually inappropriate behaviours in the month prior to the follow-up assessment.

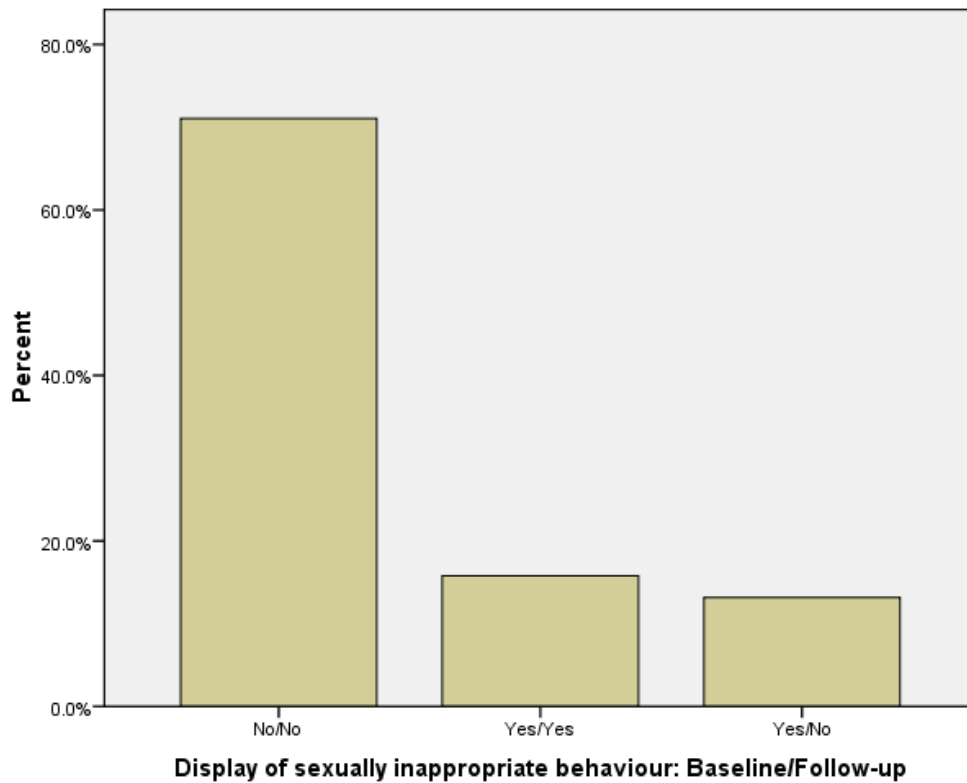
There was also a relationship between reports of sexually inappropriate behaviours and gender ( $\chi^2(1, N = 41) = 6.15, p = .024$ ). Examination of the frequencies indicates that boys (5 out of 8) were significantly more likely to exhibit sexually inappropriate behaviours than girls (2 out of 26). This is illustrated by Figure 2. It is important to note that despite the fact that there are more girls than boys in the sample, there are still more boys reported to be exhibiting sexually inappropriate behaviour (the green 'yes' column) than girls.

Figure 2. Sexually inappropriate behaviour and gender



In order to assess possible changes in sexually inappropriate behaviours from baseline to follow-up, a McNemar test was computed. Data were available for this comparison for 38 children/young people, including six of the seven children who had shown sexually inappropriate behaviours at follow-up. There was a marginally significant change in sexually inappropriate behaviour (McNemar exact test,  $p = .062$ ). A closer look at the data revealed that of these 38 children/young people, 27 (64%) had never shown inappropriate sexual behaviour, six children/young people (14%) had shown sexually inappropriate behaviour at the baseline data collection and were still showing this behaviour at follow-up, five children/young people (12%) showed sexually inappropriate behaviour at the time of the baseline data collection but were not showing this behaviour at the follow-up data collection time point. None of the children/young people who had not shown sexually inappropriate behaviour during the baseline data collection showed such behaviour at follow-up. The pattern of results can be seen in Figure 3 below.

Figure 3. Changes in the display of sexually inappropriate behaviour between the baseline data collection and follow-up.



To sum up, the majority of children/young people (83%) did not show sexually inappropriate behaviour at any time. Of the eleven children who had shown sexually inappropriate behaviour prior to the baseline assessment, six children still showed this behaviour after receiving treatment from Action for Children. However, the sexually inappropriate behaviour of five children was no longer evident between the baseline and the follow-up assessment.

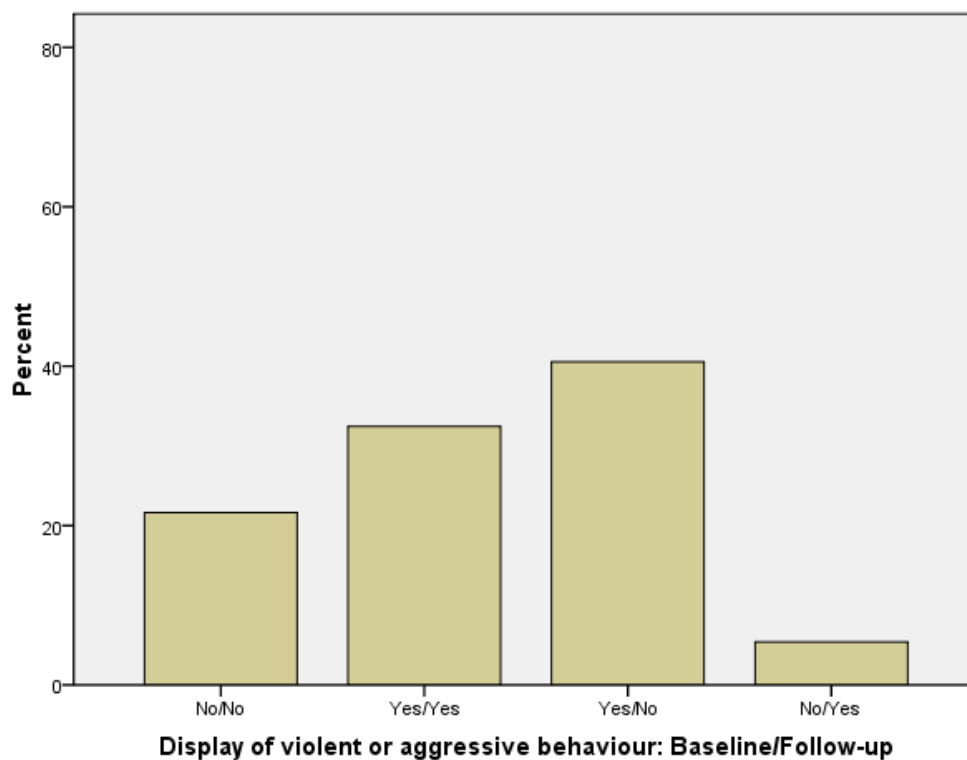
### Violent or aggressive behaviours (n = 40)

Fourteen out of 40 (35%) children/young people were reported to have displayed violent or aggressive behaviour prior to the follow-up data collection. Six of these fourteen children/young people (43%) were reported to have exhibited violent or aggressive behaviour in the month prior to data collection.

There was also a relationship between violent and aggressive behaviours and gender ( $\chi^2(1, N = 40) = 5.96, p = .015$ ). An examination of the frequency tables revealed that – despite the smaller number of boys in the sample – a greater number of boys than girls exhibited violent or aggressive behaviours.

Again, in order to assess possible changes in violent or aggressive behaviours between the baseline data collection and the follow-up data collection, a McNemar test was conducted. For this comparison, data for 37 children/young people were available. The analysis revealed that there was a significant change in the number of children/young people displaying violent or aggressive behaviours (McNemar exact test,  $p = .002$ ). Further inspection of the data showed that of the 37 children/young people included in this analysis, eight (22%) had never shown violent or aggressive behaviour and twelve children/young people (32%) had shown these behaviours at baseline and were still showing these behaviours. Furthermore, 15 children/young people (41%) had shown violent or aggressive behaviours at baseline, but were not displaying these behaviours at the time of the follow-up. However, 2 children/young people (5%) showed violent or aggressive behaviour at the time of the follow-up but had not shown such behaviours at the time of the baseline data collection. This pattern of results is summarised in Figure 4 below.

Figure 4. Changes in the display of violent or aggressive behaviour between baseline data collection and follow-up.



In summary, at the time of follow-up, 66% of the children/young people did not show violent or aggressive behaviour and boys were more likely to show violence and/or aggression than girls. The violent/aggressive behaviour of twelve children/young people, who had shown this behaviour at baseline, did not improve between baseline and the follow-up assessment. However, 15 children/young people showed improvements in violent or aggressive behaviours between baseline and follow-up, whereas two children/young people showed violent/aggressive behaviour which they had not done at baseline.

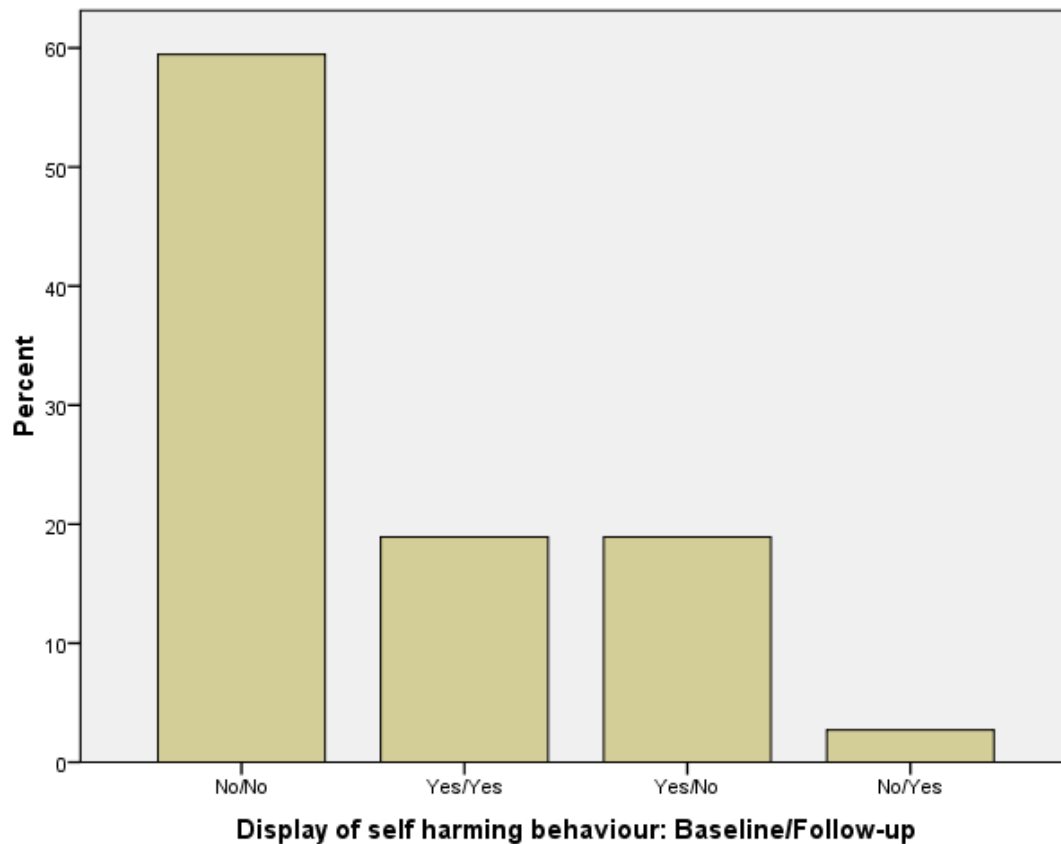
### Self-harm (n = 40)

Data on self harm at follow-up were available for 40 children/young people. Of these 40 children/young people, 32 (80%) did not show self harming behaviour at the time of the follow-up. For the remaining eight children/young people (20%) self harming behaviour was reported. A comparison of the two sexes revealed that boys and girls did not significantly differ in their display of self harming behaviours ( $\chi^2(1, N = 40) = .27, p = .613$ ).

With the aim of investigating possible changes in the numbers of children/young people for whom self harming behaviour was reported, we conducted a McNemar test. For this comparison, data for a total of 37 children/young people were available. The results of this analysis indicated that there was a marginally significant change in the number of children/young people who were reported to display self harming behaviour (McNemar exact test,  $p = .070$ ). A closer look at the data revealed that 22 children/young people (59%) neither at follow-up nor in the past had shown self harming behaviour. Seven children/young people (19%) were reported to have shown self harming behaviour at the time of the baseline data collection and were still showing these behaviours at the time of the follow-up. A further seven children/young people (19%) had shown self harming behaviour at the time of the first assessment but no longer showed these behaviours follow-up. One child/young person (3%) had not shown self harming behaviour at the time of the first assessment but showed these behaviours at the time of the follow-up. Figure 5 displays this pattern of results.

In summary, at the time of the follow-up, 80% of the children/young people in the sample did not display self-harming behaviour and there were no gender differences in the occurrence of self-harm. The self-harming behaviour improved for seven children/young people between baseline and follow-up assessment. However, one child/young person had started self-harming after the baseline assessment.

Figure 5. Changes in the display of self harming behaviour between the baseline data collection and follow-up.



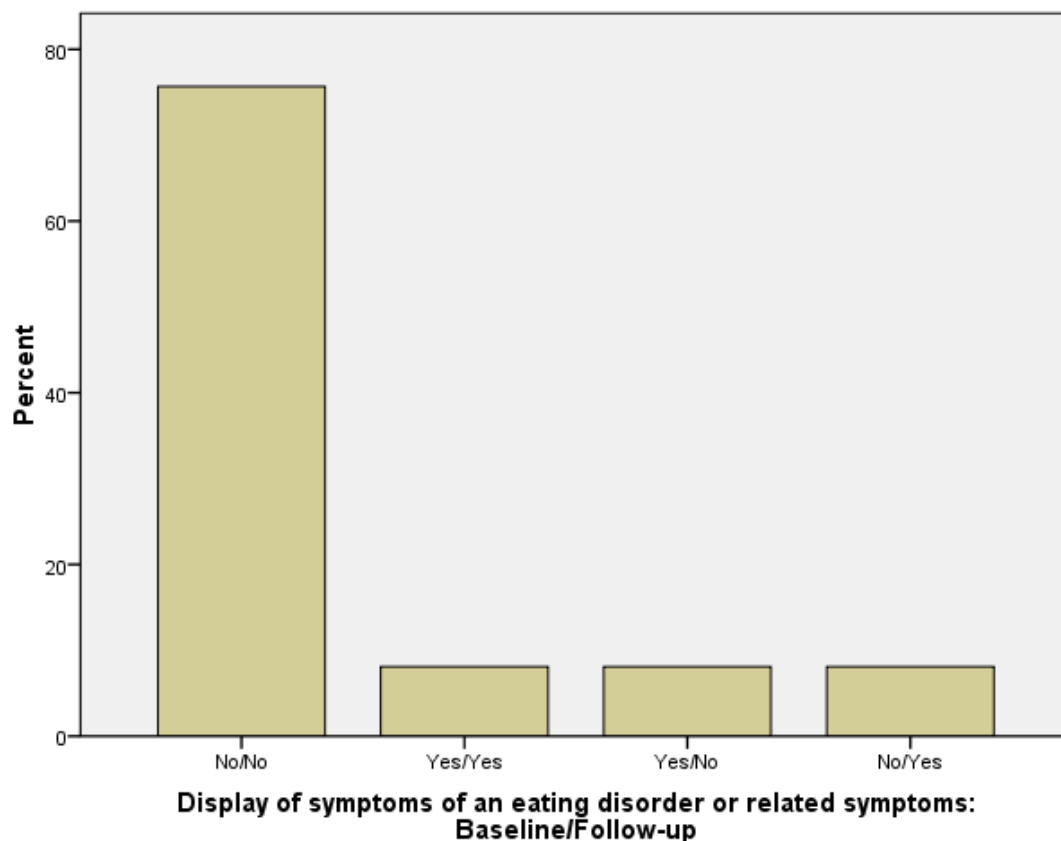
### Eating disorders and related symptoms (n = 40)

Thirty-four of the forty children/young people (85%) for whom data were available did not display symptoms of an eating disorder (including overeating) at the time of the follow-up data collection. However, six children/young people (15%) showed symptoms of an eating disorder. Two of these children/young people (5%) had shown symptoms of an eating disorder within the last six months, one additional child/young person (2%) had shown such symptoms within the last twelve months. Information is not available on the timescale for the onset of eating disorder for the remaining three children/young people who displayed symptoms of an eating disorder. Comparing boys with girls, a Chi-Square test revealed no significant differences in the proportion of boys versus girls showing symptoms of any kind of eating disorder at the time of follow-up ( $\chi^2(1, N = 40) = .81, p = .369$ ).

To investigate changes in the numbers of children/young people for whom eating disorders and related symptoms were reported, a McNemar test was conducted. For a total of 37 children/young people data on eating disorders and related symptoms were available at the baseline as well as the follow-up data collection. The results of the McNemar test indicated no significant change in the number of children who were reported to display eating disorder

related problems (McNemar exact test,  $p = 1.000$ ). Further inspection of the data revealed that out of the 37 children/young people included in this analysis, 28 (76%) had never shown symptoms of any kind of eating disorder and three children/young people (8%) had displayed symptoms of an eating disorder at the baseline data collection and still displayed such symptoms at the time of the follow-up. Three children/young people (8%) had been reported to have displayed eating disorder-related symptoms at the time of the baseline data collection, but were no longer showing these symptoms at the time of the follow-up. However, another three children/young people (8%) who had not been reported to display symptoms of an eating disorder at the baseline data collection time were showing such symptoms at the time of the follow-up. Yet, as the data from baseline report (Coren & Hutchfield, 2009b) suggest, there is a higher risk of suffering from an eating disorder or related symptoms for older children/young people (as compared to younger children/young people). Hence, as the children have become older between the baseline data collection and the follow-up, this might be not such a surprising finding. The pattern of results reported here can be seen in Figure 6.

Figure 6. Changes in the display of symptoms of an eating disorder or related symptoms between baseline data collection and follow-up.



To conclude, 85% of children/young people were free of symptoms of any kind of eating disorder at the time of the follow-up assessment and there were no gender differences in the likelihood of displaying such symptoms. Generally, the statistical analysis reveals no changes in the number of children/young people showing symptoms of eating disorders. However, a closer look at the data indicates that symptoms of eating disorders have improved for three children/young people but newly emerged in three different children/young people.

### Sleep (n = 26), nightmares (n = 26) and bedwetting (n = 29)

Nineteen out of 26 children/young people (73%) were reported to have no problems sleeping through the night in the week prior to the follow-up data collection. One child/young person (4%) was reported to have slept through only one night in the week preceding the follow-up data collection. The average number of undisturbed nights in this sample was 6.50 nights (SD = 1.24). A paired samples t-test was used to compare the number of nights with uninterrupted sleep reported in the baseline data with the number of uninterrupted nights reported in the follow-up data. This analysis revealed that the number of uninterrupted nights for the children in this sample had significantly increased ( $t(23) = -3.66, p = .001$ ). Whilst the average number of nights with uninterrupted sleep at the time of the baseline data collection was 5.21 (SD = 2.02), this number had increased to 6.46 (SD = 1.29) at follow-up.

Three out of 26 children and young people (11%) were known to have experienced nightmares at least once in the week prior to follow-up data collection. The mean incidence of known nightmares during the week prior to the follow-up data collection was .23 (SD = .71). One of these three children experiencing nightmares had one nightmare, one child/young person had two nightmares and one child/young person had three nightmares in the week preceding the follow-up data collection. In order to compare the baseline scores of the 24 children/young people for whom reports on nightmares were available for the baseline as well as the follow-up data collection, a paired t-test was conducted. The results of this test indicate a significant reduction in the number of nightmares ( $t(23) = 2.10, p = .047$ ) between the baseline data (M = .96, SD = 1.49) and the follow-up (M = .25, SD = .74).

One child/young person (3%) out of 29 was known to have wet the bed once in the week prior to follow-up data collection. None of the remaining children/young people was reported to have wet the bed in the week preceding the follow-up assessment. A paired t-test revealed that the average incidence of bed wetting in the week prior to the assessment was not significantly reduced ( $t(26) = 1.22, p = .232$ ) between the time of the baseline assessment (M = .22, SD = .85) and the time of the follow-up assessment (M = .04, SD = .19).

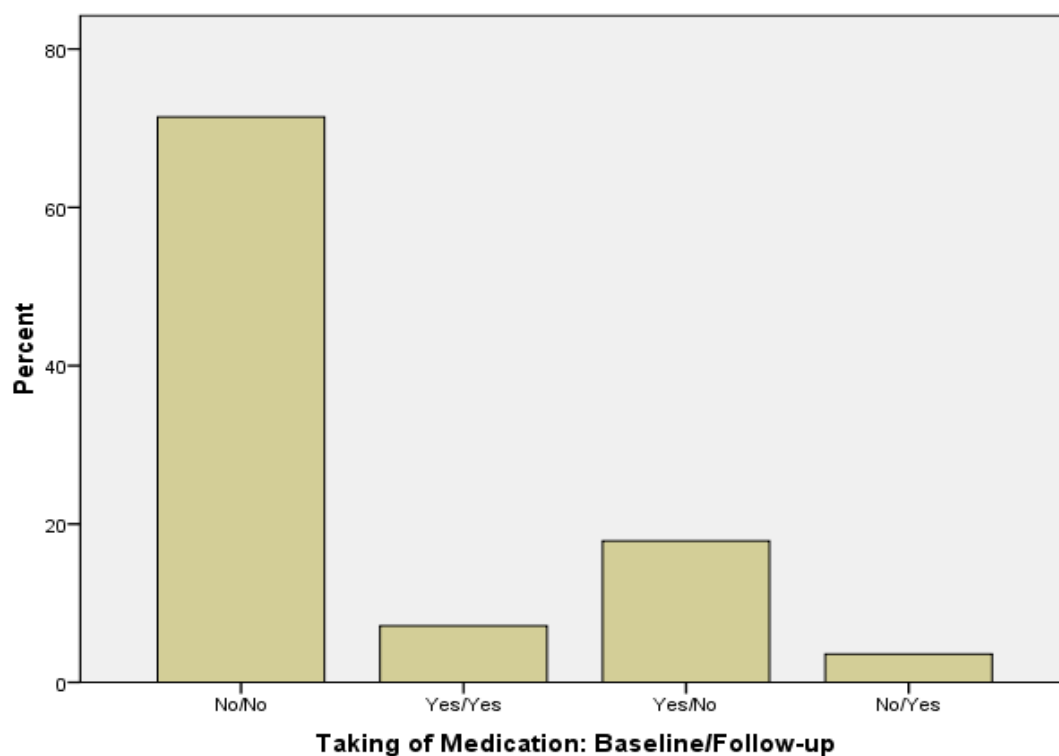
In summary, the sleep quality of the included children/young people appears to have significantly improved between baseline and follow-up assessment. Seventy-three percent of the children/young people did not experience sleep interruptions, 89% slept without nightmares and for 97% of the children/young people there were no problems with bedwetting in the week prior to the follow-up assessment. While these improvements were significant in the instance of sleep interruptions and nightmares, the average frequency of bedwetting did not change in a statistically meaningful way.

## Medication (n = 35)

Thirty-two out of 35 children/young people (91%) were reported to not take any medication at the time of the follow-up data collection. Two children/young people (6%) were reported to be taking Ritalin and one child/young person (3%) was reported to take medication other than Ritalin or Risperidone.

In order to assess whether the proportion of children/young people taking medication had changed between baseline data collection and follow-up, a McNemar test was conducted. Data for both data collection points were available for 28 children/young people. The McNemar statistic revealed that there was no significant change in the number of children/young people taking medication (McNemar exact test,  $p = .219$ ). Further analysis of the data revealed that 20 out of the 28 children/young people (71%) had never taken any medication and were not taking any medication at the time of the follow-up. Two children/young people (7%) were reported as taking medication, at the baseline as well as the follow-up. Five children/young people (18%) had taken medication at the time of the baseline data collection but were no longer taking medication at follow-up. One child/young person (4%) had not been reported to take medication at the time of the baseline data collection but had started taking medication and was still taking medication at the time of the follow-up assessment. This pattern of results can be seen in Figure 7 below.

Figure 7. Changes in the taking of medication between the baseline data collection and follow-up.



To sum up, at the time of the follow-up assessment, 91% of the included children/young people did not take any medication. Even though the change in the number of children/young people taking medication between the baseline and the follow-up assessment is not statistically significant, five children/young people stopped taking medication whereas one child/young person had started taking medication.

### Education (n = 41)

Thirty-nine out of the 41 children/young people (95%) attended education appropriate to them at the time of the follow-up. Of these 39 children/young people, 25 (83%) were reported to attend appropriate educational provision fully (100%). Two children/young people (5%) did not attend appropriate education in the week prior to data collection.

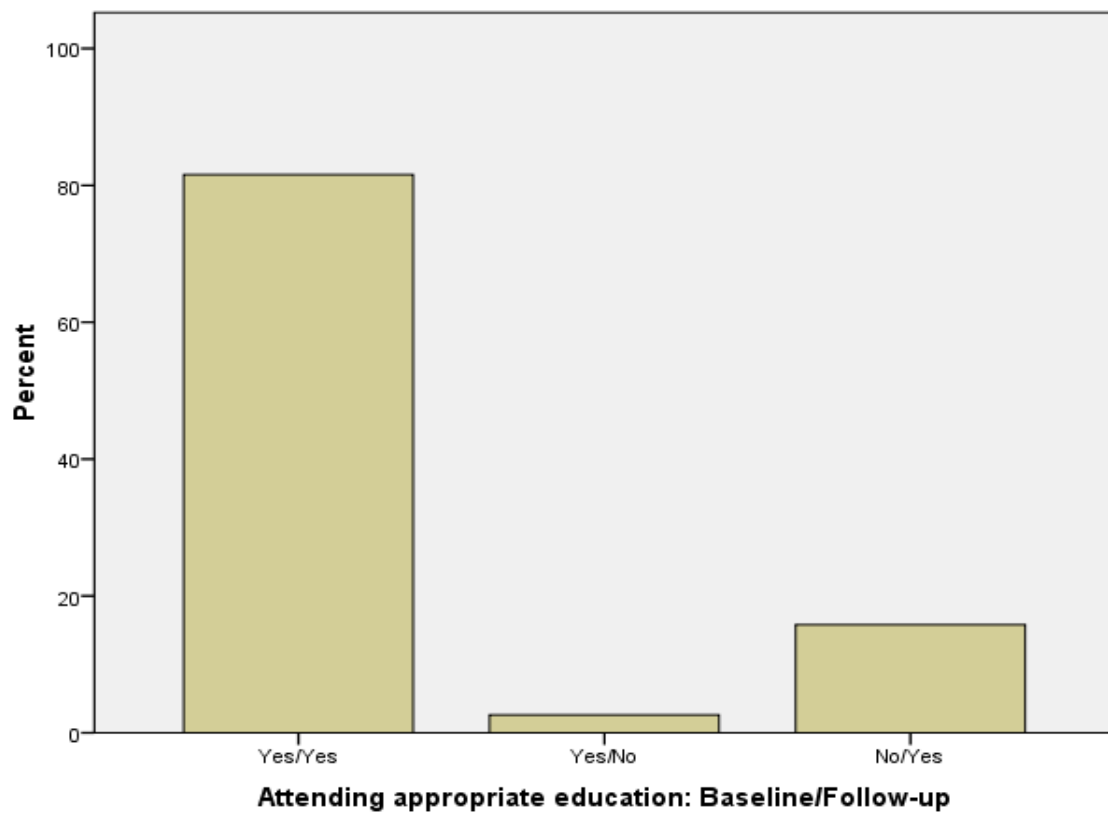
A McNemar test was conducted to assess possible changes in the proportions of children/young people attending appropriate education,. The results reveal that there were no significant changes in the attendance of appropriate education (McNemar exact test,  $p = .125$ ) between baseline data collection and follow-up. As Figure 8 below shows, there were 31 children/young people (82%) who continuously attended appropriate education, one child/young person (2%) had been in appropriate education at the time of baseline data collection but did not attend appropriate education in the week prior to follow-up data collection. Finally, six children/young people (16%) who had not been in appropriate education at the baseline data collection, attended appropriate education at the time of the follow-up.

Looking at the percentage of time the 39 children/young people attended appropriate education, 21 (84%) attended full time education (i.e., 100%), four children/young people (13%) attended education 80% of the time, and one child/young person (3%) attended education 60% of the time. A paired t-test revealed no significant changes in the percentage of time the children/young people spend in education ( $t(27) = -1.65$ ,  $p = .110$ ), with the percentage of time the children/young people spent in education being slightly lower at baseline ( $M = 88\%$ ,  $SD = 25.73$ ) as compared to the follow-up ( $M = 96\%$ ,  $SD = 9.97$ ).

In summary, the children's/young people's attendance of appropriate education did not change in a statistically significant way between the baseline and the follow-up assessments. At the time of the follow-up, 93% of the children/young people attended appropriate education, 83% of which attended full time. However, there appears to be a slight (non- statistically significant) trend that the children/young people spent more time in appropriate education at the time of the follow-up compared to the baseline. Furthermore, six children/young people who did previously not attend appropriate education were attending at the time of the follow-up. One young person who was in appropriate education at the baseline assessment was not in education at the time of the follow-up. However, this young woman was 16 years old at the time of the baseline assessment and may have completed her education.

It is possible that whilst across the group as a whole the changes reported here were not statistically significant, as with other comparisons, the changes may have been meaningful at an individual level.

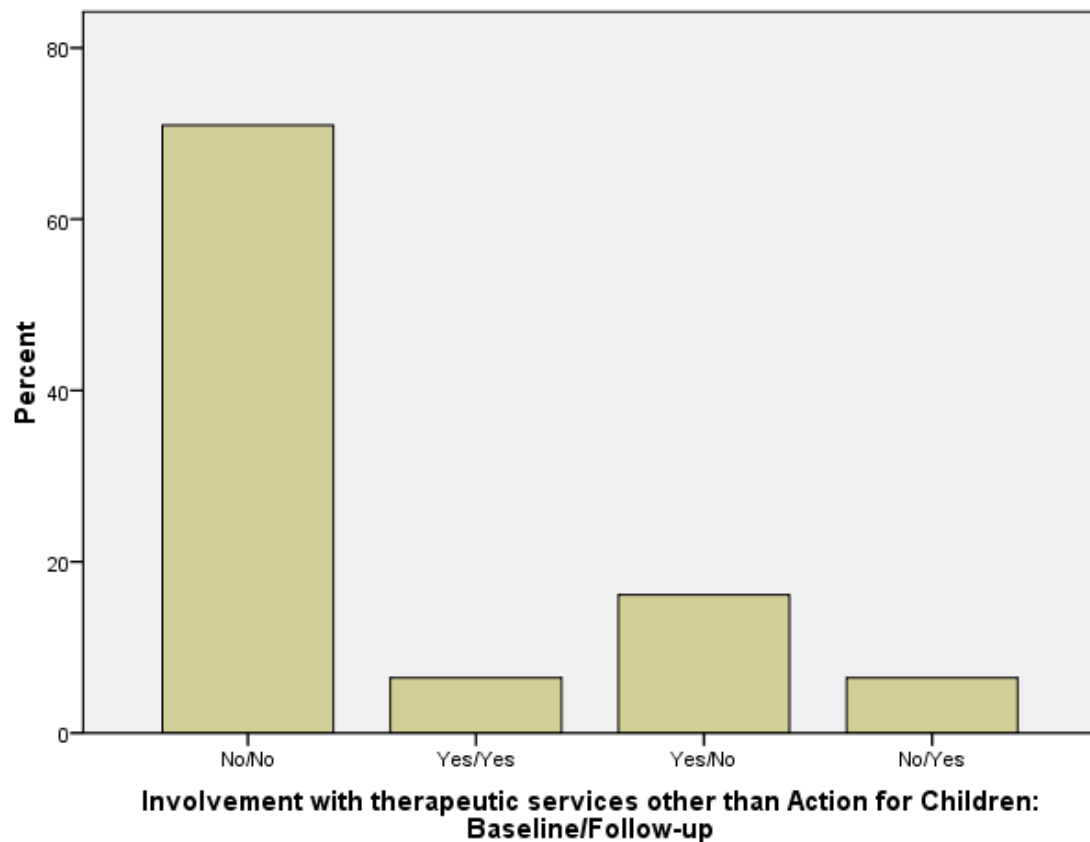
Figure 8. Changes in the attendance of appropriate education between baseline data collection and follow-up.



### Engagement with other services (n = 37)

Thirty-three out of 37 children/young people (90%) were only involved in the therapeutic services provided by Action for Children. Two children/young people (5%) were involved with the CAMHS and two further children/young people (5%) were involved with a therapeutic service other than CAMHS in addition to the service they received from Action for Children. A McNemar test revealed that there were no significant changes in the utilisation of services other than the therapeutic services provided by Action for Children (McNemar exact test,  $p = .453$ ). As is shown in Figure 9, 22 children/young people (71%) had never received therapeutic services from a source other than Action for Children and two children/young people (7%) had received therapeutic services from a source other than Action for Children and were still receiving these services at the time of follow-up. Five children/young people (16%) had received services from a therapeutic service other than Action for Children at the time of the baseline data collection but were no longer receiving these services at the time of the follow-up. The remaining two children/young people (6%) had not received additional therapeutic services at the time of the baseline data collection but were receiving such services at the time of the follow-up.

Figure 9. Changes in the involvement with therapeutic services other than provided by Action for Children between the baseline data collection and follow-up.



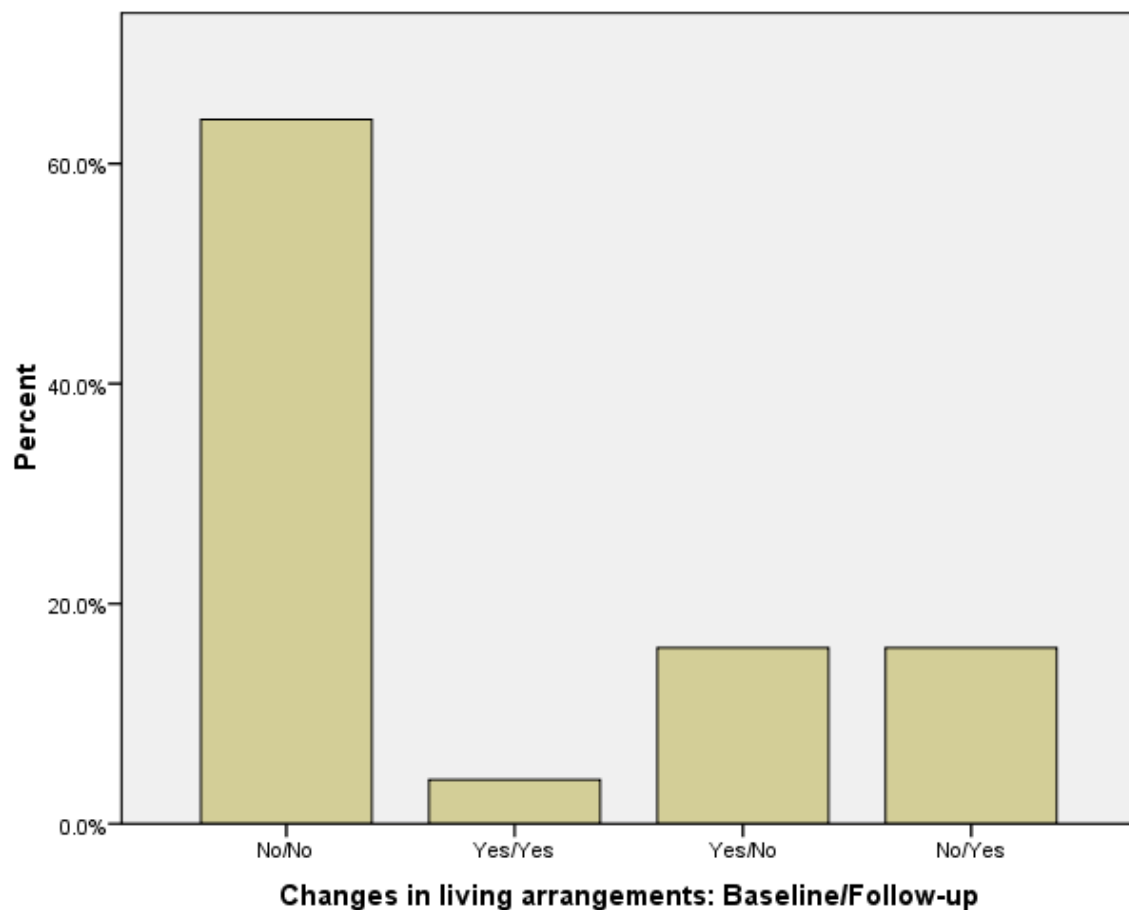
In conclusion, the majority of the children/young people were only involved in therapeutic services provided by Action for Children (90%). In comparison to the baseline assessment, there seems to be a slight (non-significant) decrease in the number of children/young people involved with services other than Action for Children. Five children/young people had stopped attending other services between the baseline and the follow-up. However, two different children/young people had taken up other services since the baseline assessment.

### Residential placements (n = 37)

Seven out of 37 children/young people (19%) experienced changes in their living arrangements since the baseline data collection. A McNemar test indicated that there were no significant differences in the number of children/young people who changed their living arrangements within the last twelve months before the baseline data collection and between baseline data collection and follow-up (McNemar exact test,  $p = 1.000$ ). For 25 children/young people data were available to compare the changes in residential placements between the baseline assessment and the follow-up. Sixteen of these 25 children/young people (64%) had never changed their living arrangements. However, one child/young person (4%) had changed their

living arrangements before the baseline data collection as well as between the baseline assessment and the follow-up. A further four children/young people (16%) had changed their living arrangements before the baseline data collection but not after, and four children/young people (16%) had changed their living arrangements between the baseline assessment and the follow-up but not before the baseline assessment. This pattern of results can be found in Figure 10 below. Furthermore, a paired-samples t-test did not reveal a significant difference in the number of residential placements the children/young people experienced ( $t(24) = -.47, p = .641$ ) twelve months before the baseline data collection ( $M = .28, SD = .61$ ) and between the baseline assessment and the follow-up ( $M = .40, SD = 1.08$ ).

Figure 10. Changes in the living arrangements between the baseline data collection and follow-up.



To sum up, there were no significant changes in the number of children/young people who changed living arrangements or the average number of changes in living conditions. The majority of the children/young people (89%) remained in stable residential placement between the baseline and the follow-up. Four children/young people who had changed their living arrangements prior to the baseline assessment had stayed in these arrangements until the time of the follow-up. However, four children/young people who had not changed their living arrangements prior to the baseline assessment had changed them between the baseline and the follow-up.

## SDQ Outcome Scales

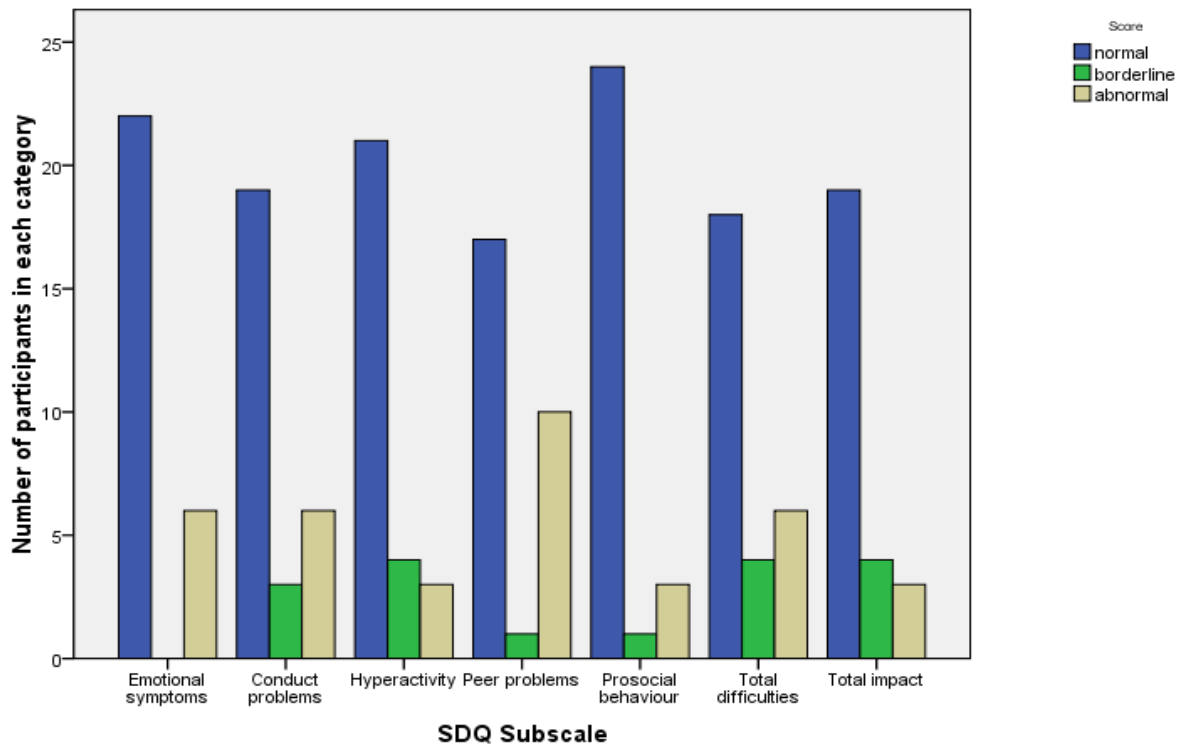
The results reported in the following section relate to the data collected using the SDQ, a short behavioural screening questionnaire assessing children’s and young people’s strengths and difficulties. For information on the transformation of the raw data into the outcomes below, please see the ‘A guide to the results’ at the beginning of the ‘Results’ section. At the second data collection time point, SDQ data were only available for 28 children/young people. Thus, table 2 below refers to these 28 young people only (N = 28 = 100%). Furthermore, for 2 children/young people (7%) the impact supplement to the SDQ was not available. For that reason, the percentages for the total impact score in the bottom row of table 2 do not add up to 100%. The findings will be summarised again at the end of this section.

**Table 2. Overall results for the SDQ banded into categories used by the SDQ.**

	<b>Normal</b>	<b>Borderline</b>	<b>Abnormal</b>
<b>Emotional symptoms</b>	22 (79%)	0 (0%)	6 (21%)
<b>Conduct problems</b>	19 (68%)	3 (11%)	6 (21%)
<b>Hyperactivity</b>	21 (75%)	4 (14%)	3 (11%)
<b>Peer problems</b>	17 (61%)	1 (3%)	10 (36%)
<b>Prosocial behaviour</b>	24 (86%)	1 (3%)	3 (11%)
<b>Total difficulties</b>	18 (65%)	4 (14%)	6 (21%)
<b>Total impact</b>	19 (68%)	4 (14%)	3 (11%)

The table above (Table 2) presents the findings for the SDQ banded in the ‘normal’, ‘borderline’ and ‘abnormal’ categories used by the SDQ. In contrast to the data pattern found at the baseline data collection time, now the majority of the children/young people score within the normal range of the SDQ. This is further demonstrated in Figure 11 below.

Figure 11. Overall results for the SDQ banded into categories used by the SDQ.



#### Emotional symptoms (n = 28)

Twenty-two out of 28 children and young people (79%) scored in the 'normal' range of the emotional symptoms subscale of the SDQ, with six children (21%) scoring zero, indicating a complete absence of negative emotional symptoms. None of the children/young people fell into the borderline category. However, six children/young people (21%) scored within the abnormal range of the emotional symptoms scale.

In order to compare the baseline scores of the 28 children/young people for whom SDQ data were available at the follow-up data collection time, a paired t-test was conducted. The results indicate that negative emotional symptoms are significantly reduced ( $t(26) = 3.36, p = .002$ ) between the time of the baseline data collection ( $M = 5.11, SD = 3.12$ ) and the time of the follow-up data collection ( $M = 3.15, SD = 3.12$ ).

#### Conduct problems (n = 28)

Nineteen out of 28 children/young people (68%) scored in the 'normal' range of the conduct problems subscale of the SDQ with only two children/young people (7%) displaying absolutely no conduct problems (score = 0). Three children/young people (11%) were classed as

borderline on this scale and a minority of six children/young people (21%) scored in the abnormal range.

Again, to assess the development of conduct problems over time, a paired t-test was conducted on the conduct problems scores. The comparison of conduct problems at the time of the baseline data collection ( $M = 3.78$ ,  $SD = 2.41$ ) with the conduct problem scores at the time of the follow-up ( $M = 3.22$ ,  $SD = 2.52$ ) revealed that – although there is a reduction in conduct problems – this difference is not statistically significant ( $t(26) = 1.33$ ,  $p = .195$ ).

#### Hyperactivity (n = 28)

Twenty-one out of 28 children/young people (75%) scored in the 'normal' range of the hyperactivity subscale of the SDQ with none of the children/young people scoring zero, indicating a complete absence of hyperactivity. Four children/young people (14%) were classed as borderline on this scale. The remaining 3 children (11%) scored in the abnormal range for this subscale.

A paired t-test revealed a marginally significant reduction in hyperactivity ( $t(26) = 1.97$ ,  $p = .059$ ) between the baseline data collection time point ( $M = 5.52$ ,  $SD = 2.79$ ) and the follow-up data collection ( $M = 4.41$ ,  $SD = 1.78$ ).

With regard to gender differences, an independent samples t-test revealed that there were no significant gender differences ( $t(26) = .72$ ,  $p = .478$ ) in hyperactivity scores for girls/young women ( $M = 4.24$ ,  $SD = 1.99$ ) compared to boys/young men ( $M = 4.73$ ,  $SD = 1.35$ ).

#### Peer problems (n = 28)

Seventeen out of 28 children/young people (61%) scored in the normal range of the peer problems scale, including four children/young people (11%) who scored zero, indicating a complete absence of peer problems. One child/young person (3%) was classed as borderline and 10 children/young people (36%) scored in the abnormal range for this subscale.

Comparing the baseline and the follow-up scores of the children/young people on the peer problems scale, we found a statistically non-significant reduction of peer problems ( $t(26) = 1.50$ ,  $p = .147$ ) between the first assessment of peer problems ( $M = 4.07$ ,  $SD = 2.30$ ) and the follow-up assessment ( $M = 3.44$ ,  $SD = 2.67$ ).

### Prosocial behaviour (n = 28)

Twenty-four out of 28 children and young people (86%) scored in the 'normal' range of the prosocial subscale of the SDQ with ten children/young people (28%) scoring the maximum possible score, indicating completely normal prosocial behaviour. One child/young person (3%) was classed as borderline and the remaining three children/young people (11%) scored in the abnormal range for this subscale.

A paired t-test comparing the baseline and follow-up scores of the included children/young people indicated no changes in prosocial behaviour scores ( $t(26) = -.08, p = .935$ ) between the baseline data collection scores ( $M = 7.93, SD = 2.15$ ) and follow-up data collection prosocial behaviour scores ( $M = 7.96, SD = 2.18$ ). Furthermore, there were no significant gender differences in the prosocial behaviour scores ( $t(26) = -1.58, p = .135$ ) between girls ( $M = 8.59, SD = 1.66$ ) and boys ( $M = 7.18, SD = 1.66$ ).

### Total difficulties (n = 28)

Eighteen out of 28 children/young people (65%) scored in the normal range of the total difficulties scale with no child/young person scoring zero on this scale. Four children/young people (14%) were classed as borderline and the remaining six children/young people (21%) scored within the abnormal range of the total difficulties scale.

There was a significant decrease in total difficulties scores over time ( $t(26) = 2.82, p = .009$ ). An inspection of the means revealed that the total difficulties scores were significantly lower at the follow-up assessment ( $M = 14.26, SD = 7.99$ ) than at the time of baseline data collection ( $M = 18.48, SD = 6.87$ ).

We also tested whether the children's/young people's total difficulties scores were related to behavioural problems such as sexually inappropriate behaviour, violent or aggressive behaviours, self-harm, eating disorders and attending appropriate education. For this purpose, a series of independent-samples t-tests was conducted. There was only a marginally significant relationship between the presence/absence of aggressive or violent behaviours and the total difficulties score ( $t(24) = -2.06, p = .051$ ), indicating a statistical trend that children/young people who displayed violent or aggressive behaviour scored higher on the total difficulties scale ( $M = 17.70, SD = 7.07$ ) than children/young people who did not display these behaviours ( $M = 11.38, SD = 7.95$ ).

It is interesting to note that the mean total difficulties score for the children/young people displaying aggressive or violent behaviours falls into the borderline/abnormal category, whereas the mean total difficulties score for the children/young people not displaying aggressive or violent behaviours falls into the normal/borderline category. As the SDQ scores used in this evaluation are a mixture of self-reports and informant-reports, a clear categorisation is not

possible on the basis of aggregated data, as the classification is slightly different for these two different types of SDQ scores.

Furthermore, correlation analyses were conducted in order to link the children/young people's total difficulty scores to their reported sleeping problems and the experience of nightmares. These analyses revealed that children/young people with higher total difficulties scores also reported more nightmares ( $r(21) = .56, p = .005$ ) and more interrupted sleep ( $r(22) = -.52, p = .010$ ) in the week preceding the follow-up assessment. According to the Diagnostic and Statistical Manual of Mental Disorders – IV (American Psychiatric Association, 1994) this combination of symptoms can be an indicator of post-traumatic stress.

### Impact (n=26)

For two children/young people there were no impact data for the SDQ available. Therefore, the analyses for the impact scale only refer to a sample consisting of 26 children/young people. Nineteen children/young people (73%) scored within the normal range for the total impact on their lives of the difficulties they had experienced. Four children/young people (15%) scored in the borderline range for this impact. The remaining three children/young people (12%) scored in the abnormal range, which indicates that the difficulties experienced by the children/young people had impacted a great deal on their lives.

Comparing the baseline impact scores and the follow-up impact scores of these 26 children/young people, a paired t-test revealed a significant reduction of the negative impact the children's/young people's experiences had on their lives ( $t(24) = 3.59, p = .001$ ). The impact scores were significantly higher at the time of the baseline data collection ( $M = 2.32, SD = 2.73$ ) than at the time of the follow-up assessment ( $M = .64, SD = 1.32$ ).

Similarly to the procedures used for the total difficulties score reported above, we conducted a series of independent-samples t-tests in order to establish the relationships between the children's/young people's impact scores and behavioural problems such as sexually inappropriate behaviour, violent or aggressive behaviour, self-harm, eating disorders and attendance at appropriate education. None of these tests showed a significant relationship between behavioural problems and children's/young people's impact scores.

Finally, correlation analyses revealed that the impact subscale was significantly correlated with the incidence of interrupted sleep and nightmares in the preceding week. The correlations indicate that children/young people who scored higher on the impact scale also experienced more nightmares ( $r(19) = .61, p = .003$ ) and interrupted sleep ( $r(20) = -.60, p = .003$ ) in the preceding week. Again, this combination of symptoms can be an indicator of post traumatic stress in the affected children/young people (American Psychiatric Association, 1994).

## Summary of SDQ findings

Overall, the outcomes assessed using the SDQ indicate improved strengths and decreased difficulties in the behaviour of the included children/young people. Statistically significant improvements between the baseline and the follow-up assessments became apparent for emotional symptoms, the total difficulties experienced and the impact of the experienced difficulties on the children's/young people's lives. There were no changes whatsoever in prosocial behaviour. However, non-significant trends in the expected direction were found for conduct problems (reduced), hyperactivity (reduced) and peer problems (reduced). Generally, the majority of children/young people (61 – 86%) scored within the normal range of the assessed behavioural variables.

## Child Outcomes evaluation results: Qualitative Evaluation

As can be seen in the data break-down shown in Figure 1, three children completed an activity book. The following section will outline the findings from this qualitative element of the evaluation for those three children in more detail. Due to the small sample size for this element of the evaluation, the results that follow should be considered as illustrative rather than representative.

### Feelings

#### Feelings before and after therapy

Children were first asked to think about how they felt before and after therapy. The activity book presented children with pictures of eight different faces which represented eight different emotions: Happy, sad, confused, angry, embarrassed, guilty, ashamed and alone. Children were asked to place a tick next to the faces which represented how they felt before attending therapy and after attending therapy. They could tick more than one face.

The findings reveal that only one of the three children reported feeling happy before therapy, however, all three children reported feeling happy after therapy. Two out of three children reported feeling sad before therapy, but only one reported feeling sad after therapy. Two out of three children reported feeling confused before therapy, but only one still reported feeling confused after therapy. Two children reported feeling angry before therapy, but only one still reported feeling angry after therapy. One child reported feeling embarrassed before therapy, but none felt embarrassed after therapy. One child reported feeling guilty before therapy, whereas none of the children reported feeling guilty after therapy. One child reported feeling ashamed before therapy, but none reported feeling ashamed after therapy. Two children reported feeling alone before therapy, whereas only one reported still feeling alone after therapy.

One child who had ticked all the emotion faces as feelings they experienced before therapy went on to write that they felt all these emotions at some time: I felt ... "them all at different times". In contrast, after therapy, although this child still ticked the 'sad, confused, angry, alone and happy' emotions they no longer reported feeling 'embarrassed, guilty or ashamed'. One child went on to explain that prior to attending therapy that they felt that: "it was my fault and I was sad, angry at my family for not believing me", but after therapy they felt: "happy and sometimes sad and I no (know) that I am not alone, but more for the time I am happy". Another went on to write that prior to therapy they felt "down, not happy and confused" but that after receiving therapy they felt "happy".

On the whole, therapy appeared to reduce children's negative feelings; however, although children appeared to feel much happier after receiving therapy, this was still mixed with a number of negative feelings.

### Perceptions of self

Children were asked about how they felt inside and how they thought other people saw them from the outside. All children reported that they now felt "happy" inside, however, two out of the three children still reported mixed feelings. As well as feeling happy inside one child also still reported feeling "sad" and the other still reported feeling "angry and confused" inside. Two children reported how they thought other people saw them from the outside. Both of these children thought that others saw them as "happy and normal". Interestingly there appears to be some discrepancy between how these children really feel inside and how they think others see them. Although the children perceived that others saw them as "happy and normal" how they reported feeling inside remained mixed and included feelings of sadness, anger and confusion.

### Daily Life

Children were asked how they were coping in relation to a number of daily life activities and were asked to rate the extent to which their management of daily life activities were positive or negative after attending therapy on a six point Likert scale. Likert scales are one-dimensional ordinal scales that measure the strength of agreement to a particular statement. One end of the scale represents a negative response; the other end of the scale a positive response. In this case, the scale was formatted as ladder, with each rung of the ladder representing a number from one to six. In addition, children were asked to state whether experience of daily life activity had 'got better', 'not changed' or 'got worse'.

The following headings reflect the headings used in the workbook itself. Explanations as to how to answer the questions were given for each heading in the workbook.

### How do you sleep?

On a rating scale of 0 being 'not well' to 6 being 'well', two out of the three children reported their ability to sleep was above 4, suggesting that they felt they slept quite well. However, one child rated their sleeping as 0 suggesting they were not sleeping well at all. This child also claimed that their sleep had not changed since beginning therapy. Another child who rated their sleep as 5 also said that this had not changed since starting therapy. This suggests that sleep was not an outcome that changed for two of the three children after receiving therapy. However, the third child who reported their sleep to be 4 claimed that this had improved since therapy.

### How much do you worry?

On a rating scale from 0 being 'a lot' to 6 being 'not a lot' one child claimed to be still very worried and rated their worry at 0 'a lot'. Another child rated their worry at 3, half way between being worried a lot and not at all. The final child claimed to be not particularly worried, rating their worry to be 5. Although the extent to which these three children worried varied, all of them claimed that their worry had got better after receiving therapy.

### Do you eat regularly?

On a rating scale from 0 being 'never' to 6 being 'always', two children reported that they tended to eat regularly and rated their eating regularly at 5. One child however, rated their eating regularly as a low 2. This child claimed that therapy had not changed their eating habits. Similarly, a child who considered themselves to eat regularly also claimed that therapy had not changed their eating habits. However, one child who did report regular eating habits did consider this to have been improved after therapy.

### Do you like the way you look?

On a rating scale from 0 being 'never' to 6 being 'all the time', one child rated the way they looked as 0 and another rated their looks as 1, suggesting very negative self images. The child who claimed to never like the way they looked reported that this had got worse after therapy. The other child, who also rated their self image as very low, thought that this had not changed after therapy. Although the final child rated their looks as 5 and suggested that they tended to like the way they looked most of the time, they did not think this self image perception had changed after therapy.

### Do you feel different from others?

On a rating scale from 0 'always' to 6 'never' two children gave this question a rating of 0 which suggests that they always felt like the 'odd one out'. These two children also reported feeling that this had not changed after therapy. The third child gave this question a rating of 5 suggesting that they hardly ever felt like the 'odd one out'. They did not state however whether this had changed after therapy.

### Can you concentrate?

On a rating scale of 0 'never' to 6 'always', two children rated their concentration to be 4 or above, suggesting that their concentration was good. These same two children reported that this had improved after therapy. One child however claimed that they could never concentrate as they scored this question 0. This child also stated that this had not changed after therapy.

### Behaviour

#### Behaviour towards children or young people living with you

Two children reported that after therapy their behaviour towards siblings had got better, but one child reported that this had got worse.

#### Behaviour towards parents or carers

One child reported that their behaviour towards their parents/carers had got better, whereas another reported that it had got worse and another that it had not changed.

#### Behaviour towards school, college or work

Two children reported feeling that their behaviour towards school, college or work had got better after therapy, but one child reported feeling that it had not changed.

#### Perceptions of own behaviour and other people's perceptions of their behaviour

One child reported feeling that after therapy overall they had 'improved mood and improved behaviour'. When the children were asked how they saw their own behaviour, two children thought their behaviour was good and one reported that it had 'got better since project'. These children also thought that other people saw their behaviour to be good. However, one child considered that although other people saw their behaviour as good, they themselves felt that their behaviour was bad.

### My Future

When children were asked to draw or write about what they saw in their future, all children produced positive feedback. All expected that their future would be happy and wrote: "that I will be happy", "a happy life" and in my future I see "my Ma, my Pa and Ben P and Lucy H". The child who mentioned their family and friends in their future additionally drew a picture of two people smiling. Over the top of one of the people the child included the label "mam" and so we presume this child links their future being happy with their family. In addition, the child drew what appears to be a rabbit lying on its side at the end of a path. The interpretation of this rabbit is open to suggestion as pictures drawn by young children often can be.

## Me and My Project

Children were asked in general how they felt about coming to the project. They were asked whether coming to the project was good, bad or they didn't know. Two children reported that coming to the project was good, whilst the third child did not comment. Finally, children were asked why they liked coming to the project and why they did not like coming to the project. None of the children commented on any negative aspects of coming to the project, but one child did comment on positive aspects and claimed to enjoy painting at the project, writing ' I like painting'. They then draw a picture of themselves smiling and holding a paint brush.

## **Strengths and Limitations of the Quantitative Part of the Evaluation (Questionnaires)**

The evaluation reported here has a number of strengths and limitations, which shall be discussed in the following paragraphs. Firstly, we shall focus on the strengths and limitations of the quantitative part of the evaluation (questionnaires). This will be followed by a brief outline of strengths and limitations of the qualitative element of the evaluation (activity books).

### Strengths

In terms of ecological validity, it is a strength of the evaluation that the research reported here was embedded within existing therapeutic interventions provided by Action for Children and that the projects and staff within the 'Safe and Secure' network were involved in this evaluation. Moreover, it is an interesting aspect of the evaluation that the outcomes evaluated have been determined in collaboration with practitioners with extensive experience of working with sexually abused children. This element would of course have been strengthened were resources and time available to also consult with children and parents about what they considered important.

The fact that this evaluation looks at an UK based intervention adds to the literature in the field. The qualitative component of this research further expands our understanding of the children's views of sexual abuse therapy. In particular, one of the major strengths to arise from the qualitative evaluation is the production of the activity book as a tool for evaluating children's perspectives of therapeutic intervention. Finally, the fact that Action for Children dedicated time and resources to the evaluation of its services to children and young people cannot be regarded highly enough: Action for Children thereby contributes to ensuring the quality of its services as well as to the generation of knowledge in an important but under-researched area.

## Limitations

However, this evaluation also has limitations. These include the lack of a control group, the 'self-selection' of participating children/young people at the follow-up assessment stage, the variety of treatments offered and implemented across projects, statistical problems such as regression towards the mean, the ways data were gathered (via the assessed projects, parents and therapists), a generally small sample size and some children's/young people's involvement with other therapeutic services.

### The lack of a control group

In the current evaluation, t-tests and McNemar tests were employed to determine whether there is a significant difference between the baseline and follow-up scores of the included children/young people. However, the design used in this evaluation does not include a control group of comparable children/young people, who did not receive the services offered by Action for Children. Hence, the evaluation at hand does not allow for the conclusion that the treatment provided by Action for Children is solely responsible for the improvements in the children's/young people's functioning and daily life experiences.

Based on the available data, we cannot rule out the possibility that the differences in child outcomes are not due to one or more other variables that intervened between the baseline and the follow-up assessment. For this reason, future evaluations should insure that an adequate control group is included in the assessments. This comparison group – which should not be exposed to the treatment and could be a waiting list control group – would enable researchers to rule out the potential influence of confounding variables (see Sheskin, 2000).

### Self-selection of participants

The second limitation is that the children/young people, who remained in the evaluation for follow-up, might not be representative of the initial sample in the baseline assessment and of sexually abused children in general. The high attrition rate of children/young people between the baseline and the follow-up assessment lowers the statistical power and cannot be assumed to be random with respect to the children's/young people's outcomes (Shadish, Cook & Campbell, 2002).

The drop out of treatments and treatment-related research has been shown to be systematically biased (e.g., Kazdin, Mazurick & Bass, 1993). This means that those who drop out may be systematically different from those who remain in the intervention. Kazdin et al. (1993) point out that attrition can also be determined by factors that take place after the treatment has begun. Of particular importance here are processes that emerge in treatment such as the therapeutic alliance and the congruence of parental expectations with the treatment methods. However, as Ribisl, Walton, Mowbray, Luke, Davidson and Bootsmiller (1996) argue, a certain amount of attrition is usually unavoidable in longitudinal research and a sufficient allocation of time, personnel and money is needed to successfully track participants for follow-up assessments.

### Variations in treatment

Shadish et al. (2002) discuss a further limitation, which may apply to the findings reported in this evaluation. According to these authors, the conclusions that can be drawn are limited if treatments (in this case the services provided by Action for Children) are implemented inconsistently between different projects and between different people within the projects. However, given the nature and organisation of the services provided by Action for Children, which are all different, this lack of standardisation is unavoidable and – as Shadish et al. (2002) mention – is often intrinsic to real-world (rather than purely experimental) interventions.

### Regression towards the Mean

A possible alternative explanation for the longitudinal findings presented in this report has been pointed out by Campbell and Stanley (1963). This alternative is called “regression towards the mean”. According to Hsu (1995), regression towards the mean means that the score each person is expected to have after receiving psychotherapy is usually closer to the group mean than the score which was measured for that person before they received therapy. However, this cannot be interpreted as an effect of psychotherapeutic treatment but is a statistical problem based on measurement errors. Therefore, when people with extreme scores (i.e., abnormal scores) are selected for psychotherapy, there will be a natural statistical tendency for them to score less extremely in the follow-up assessment. Campbell and Stanley (1963) emphasise that this should not be mistaken for a treatment effect and this report cannot rule out this alternative explanation for at least some of the findings.

### Data collection practice

Another point has to be made about the way data were collected in this outcome evaluation. This was mainly undertaken by the included projects and therapists, and in some instances via the parents (completing the SDQ). A serious limitation of the data presented in this report therefore, may be the vested interest the parties involved in data collection have in obtaining positive results in this evaluation. The therapists and project staff of Action for Children were strongly involved in the data collection for this evaluation, thus, in research terms they acted as “experimenters”. The literature strongly supports the notion that the expectations of the experimenter can have a strong impact on the outcomes (see Luborsky et al., 1999; Rosenthal & Frank, 1956) and it appears to be quite natural that therapists who hold strong allegiances to specific interventions are likely to give every advantage to their brand of therapy – often without being aware of it (Lambert, 1999). Thus, it is not possible to rule out the presence of what Luborsky et al. (2002) call an ‘allegiance effect’ as a possible confounding factor that influenced the results presented in the current report.

### Small sample size & involvement with other therapeutic services

Given that 585 children and young people were referred to Action for Children in 2007 and that our evaluation initially started off with a sample of 86 children/young people, the small sample size for the outcomes reported in this report should be considered as problematic. While

large samples are highly representative of the population from which they are drawn, this cannot be said about small samples (Tversky & Kahneman, 1971). Readers of this report should make sure that they do not have exaggerated confidence in the validity of the conclusions presented in this report (see Tversky & Kahneman, 1971).

Moreover, four children were involved with therapeutic services other than those provided by Action for Children, which is a further threat to the conclusion that the psychological and behavioural improvements reported here are solely due to the services provided by Action for Children. Thus, the fact that a number of children received services on top of those provided by Action for Children may confound the results in this report in terms of causation for these children.

## **Strengths and Limitations of the Qualitative Part of the Evaluation (Activity Books)**

### Strengths

Although the qualitative assessment using the activity books was limited by low participation numbers, it should be noted that children's views of sexual abuse therapy are very rarely collected in research. Therefore, even taking into account low participation, this research expands our understanding of the effectiveness of child sexual abuse therapy. It additionally highlights lessons to be learned about collecting such data, especially the barriers of using intermediaries (in this case therapists) to collect data on behalf of researchers.

In general, studies with rigorous ethical stance like this, that are explicit about the nature of the research, use intermediaries and require participants to opt-in, tend to get a lower response rate (Prior, Lynch & Glaser, 1994; Lynch, Glaser, Prior & Wood, 1999). In this way, the experience of this evaluation is consistent with others. However, one of the major strengths to arise from this qualitative evaluation is the production the activity book. One possible outcome of this research is that this activity book can be used as an evaluative tool of therapeutic interventions for children who have experienced sexual abuse.

### Limitations

The qualitative analysis was however limited by the low number of young people who participated in this part of the evaluation. Although it is important to get the views of children and young people, only three activity books were returned. Recording the views of vulnerable groups such as this is always a challenge for researchers. In this case, there were a number of physical and human barriers that blocked young people's access to the activity books even before they had the chance to consent. Since it would be ethically inappropriate for the researchers themselves to approach young people in therapy, therapists were asked to invite young people to take part in the research by completing an activity book. However, sometimes

cases closed or young people did not come to therapy appointments, in which case therapists were unable to invite them to take part in the research. Moreover, in other cases, therapists themselves selected which children they thought were or were not appropriate to approach.

Although project staff were initially consulted about the suitability of the child/young person prior to sample selection, in subsequent interviews, it emerged that some therapists further excluded children/young people from the selected sample: "I introduced the workbook to one young person, there were a couple of others which I possibly could have asked, but they were unsuitable", "There were four possible young people to approach to use the workbooks, however, two were inappropriate", "I think the use of the workbook very much depended on the age and gender of the young person. I think a teenage male would be put off by the child-like presentation of the activity book".

This reduced the numbers of young people being approached for consent even further. Desire to protect the child is understandable, but can reduce willingness to ask a child to participate in research (Lynch et al, 1999). Intermediaries can impact on sample size if their relationship with the sample makes them unwilling to invite participation in research, if they are hostile to research or if they have difficulties explaining the research to participants (Lynch et al, 1999). Those invited to take part had the right to refuse or withdraw and, as expected, not all young people approached wished to take part. However, in one known case, a young person did consent and took an activity book away with them, which then was not returned to the project or to the researchers at Canterbury Christ Church University.

Further potential limitations of the qualitative work relate to the child's perception of the task. Firstly, although it was made clear to children that the workbook would not be shown to therapists, children might still wish to please these important adults in their lives, and this might influence their response to the activities. In addition, children who may have been in therapy for some time were asked to comment on aspects of well-being prior to starting therapy. Their recollection may have been affected by a number of factors, including possible difficulties in remembering objectively how they felt in the past. This might be particularly relevant where children are very young. Finally, even though the research team at CCCU consulted therapists about which outcomes they considered to be important, no attempt was made to consult the children/young people and/or their parents/carers about which outcomes they considered important.

## Summary of Main Findings

The aim of this follow-up report of the evaluation was to investigate the changes in the outcomes for children/young people following interventions in the aftermath of sexual abuse. The children/young people to whom this report refers received interventions through Action for Children's "Safe and Secure" Network. This report presents the final analyses and comparison of the data collected during the baseline and the follow-up assessment. In the following paragraphs we will outline the main findings of this final report.

1. Sexualised behaviour
  - 1.1. This was assessed using a follow-up form completed by the therapist. The results indicate a slightly reduced occurrence of sexually inappropriate behaviour
2. Violent/aggressive behaviour
  - 2.1. This was assessed using a follow-up form completed by the therapist. There was a significant reduction in the number of children/young people who showed violent or aggressive behaviour after undergoing the interventions provided by Action for Children in comparison to before receiving services.
3. Self harm behaviour
  - 3.1. This was assessed using a follow-up form completed by the therapist. There is a marginally significant decrease in the number of children/young people who engaged in self harming behaviours.
4. Anger/flashbacks/nightmares/bedwetting
  - 4.1. This was assessed using a follow-up form completed by the therapist and the qualitative workbook. Anger reduction was assessed using aggressive behaviour as a proxy (see point 2 above). The findings further indicate better sleep quality and fewer nightmares at the follow-up assessment compared to the baseline assessment. There were no significant differences in the frequency of bedwetting.
5. Attendance at appropriate educational provision/employment
  - 5.1. This was assessed using a follow-up form completed by the therapist. There was a non-significant increase in the number of children/young people who attended appropriate education.
6. Referrals to other agencies
  - 6.1. This was assessed using a follow-up form completed by the therapist. There appears to be a slightly reduced number of children/young people who are involved with services other than those provided by Action for Children.
7. Residential placements
  - 7.1. This was assessed using a follow-up form completed by the therapist. There were no significant decreases in the number of children/young people who changed living arrangements after being involved in services provided by Action for Children.
8. Mental health symptoms and emotional well-being
  - 8.1. These were assessed using the SDQ (completed either by the parents or the child/young person themselves). There were significant decreases in the total difficulties experienced by the children/young people and a significantly reduced negative impact of these difficulties on the children's/young people's daily routines. Furthermore, the SDQ data indicate significantly lower emotional problems scores.

## 9. Social relationships

9.1. This was assessed using the SDQ. The prosocial behaviour of the included children/young people did not change significantly between the baseline and the follow-up assessment.

## 10. Emotions and feelings

10.1. This was assessed using the SDQ. In contrast to the baseline assessment, the majority of the included children/young people scored within the normal bands of the SDQ (see also point 8 above).

## 11. Feelings of blame, guilt, shame and stigma.

11.1. This was assessed using the qualitative activity book. Three children expressed their opinion about their therapeutic intervention: Two out of the three children reported that therapy had not changed the way they felt about themselves as the 'odd one out'. One child reported feeling guilty, ashamed and embarrassed before attending therapy, however, none of the children reported feeling guilty, ashamed or embarrassed after therapy.

Further to this outline of the main findings, there are other factors to be taken into consideration when reading this report. Firstly, there are – like in the baseline report – more girls than boys in the follow-up sample, which reflects the actual demography of service users. Secondly, like in the baseline report, there is a gender bias in the exhibition of sexually inappropriate behaviours, showing that boys in the sample were more likely to show these behaviours than girls. This finding is consistent with research discussed by Bentovim and Williams (1998). However, this gender bias was not replicated in the follow-up assessment for hyperactivity in the children/young people. Finally, this report and the methodology applied in the evaluation have serious limitations that do not permit simple causal interpretations of the data obtained. However, for almost all measured indicators of behavioural and psychological problems of the children/young people assessed in this evaluation there is a – sometimes statistically significant – trend to improvement in the problems experienced at the start.

## Conclusions – Relating the Report to the Aims of the Evaluation

In summary, we will now address the aims stated at the beginning of this final evaluation report and relate them to the findings of the current evaluation of services provided by Action for Children.

- *Developing a strategic overview of child sexual abuse projects.*
  - This aim has been achieved by delivering the general evaluation report by Coren and Hutchfield (2009c) to Action for Children. This report focused on the processes and patterns which underpin the running of each of the included 8 projects within the 'Safe and Secure' network. The report concluded that in 2007, therapeutic services were provided to a large number of children/young people, however, across projects, the number of non-White children/young people receiving services was low and more funding would allow for a greater coverage of the needs and demands arising from the community.
- *Evaluating working practices.*
  - This aim also has been addressed in the general evaluation report by Coren and Hutchfield (2009c). Coren and Hutchfield (2009c) concluded that the projects are well known to referrers, appear to have good relationships with the communities and dedicated project staff, who offer a wide range of therapeutic approaches. However, there is also a lack of a standard recording framework, making sustainable evaluation difficult. All but one of the projects included in the evaluation further had some level of waiting list in 2007.
- *Providing empirical evidence of outcomes for children/young people who have received child sexual abuse support services.*
  - The current evaluation took a longitudinal as well as a qualitative approach to investigate the outcomes for children/young people who have experienced child sexual abuse and have been offered and provided services by Action for Children's "Safe and Secure" Network. This report provides evidence that the children's/young people's psychological and behavioural problems decrease. However, as has been stated in the limitations section of this report, we cannot causally infer that this is exclusively due to the services provided by Action for Children.
- *Providing evidence of the need for and the impact of child sexual abuse support services.*
  - As can be seen from the baseline report (Coren & Hutchfield, 2009b), most children/young people referred to Action for Children's "Safe and Secure" Network and included in this evaluation, scored within the abnormal bands of the SDQ at the baseline assessment. Thus, as only ten percent of the normal population score within this abnormal range, there is potentially a disproportionate need to provide interventions for children/young people and their families in the aftermath of child sexual abuse. Even though there are limitations to the design of this evaluation and therefore to the interpretation of the data reported in this report, the report at hand provides evidence that the children's/young people's scores tend to normalise after receiving the services.

- *Supporting the need for early intervention and the increase in therapeutic support services to children who have been abused.*
  - This aim strongly relates to the two bullet points above. It is particularly relevant to note that the children's/young people's psychological and behavioural problems improved after receiving the services provided by Action for Children.
- *Supporting capacity building within Action for Children and contribute to the planning and provision of additional child sexual abuse services across the UK.*
  - This aim was addressed indirectly within this evaluation. The several parts of this evaluation strongly support the notion that the services provided by Action for Children's 'Safe and Secure' network are beneficial to children/young people who have experienced sexual abuse.
- *Supporting the negotiations with statutory partner agencies towards the development of additional services.*
  - Like the previous aim, this aim was addressed indirectly by the evaluation by showing the beneficial nature of the services provided by Action for Children's 'Safe and Secure' network.
- *Providing a robust monitoring mechanism by which the service can review and evaluate progress.*
  - Again, this aim was addressed indirectly in this evaluation. A robust monitoring mechanism could for example be based on the tools (baseline and follow-up forms, activity book) the researchers from Canterbury Christ Church University developed. However, we strongly recommend the involvement of external experts for collecting, processing and analysing data used to evaluate the services.
- *Taking account of and working in harmony with other appropriate service providers.*
  - This final aim was also addressed indirectly. Following the evidence of effective services provided by Action for Children, however, it is now the responsibility of the individual projects to get involved or continue the involvement with other service providers.

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## References

Action for Children (2009). Survive and thrive in *The Guardian*, Saturday 28<sup>th</sup> March, 2009. Available from: <http://www.guardian.co.uk/action-for-children/survive-and-thrive>. Accessed 30<sup>th</sup> October 2009.

Allnock, D., Bunting, L., Price, A., Morgan-Klein, N., Ellis, J., Radford, L. & Stafford, A. (2009) Sexual abuse and therapeutic services for children and young people: The gap between provision and need. Available from: [http://www.nspcc.org.uk/Inform/research/Findings/sexual\\_abuse\\_therapeutic\\_services\\_report\\_wdf68558.pdf](http://www.nspcc.org.uk/Inform/research/Findings/sexual_abuse_therapeutic_services_report_wdf68558.pdf)

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4<sup>th</sup> Ed.)*. Washington, DC: American Psychiatric Association

Arellano, C. M. (1996) Child maltreatment and substance use: A review of the literature. *Substance Use & Misuse*, 31 (7), 927-935.

Bentovim, A. & Williams, B. (1998). Children and adolescents: Victims who become perpetrators. *Advances in Psychiatric Treatment*, 4, 101-107.

Bolger, K.E. & Patterson, C.J. (2001). Pathways from child maltreatment to internalizing problems: Perceptions of control as mediators and moderators. *Development and Psychopathology*, 13, 913-940.

Briere, J.N. & Elliott, D.M. (1994). Immediate and long-term impacts of child sexual abuse. *Sexual Abuse of Children*, 4 (2), 54-69.

Campbell, D.T. & Stanley, J.C. (1963). *Experimental and quasi-experimental designs for research*. Chicago: RandMcNally.

Capps, L., Sigman, M., Sena, R., Henker, B. & Whalen, C. (2006) Fear, anxiety and perceived control in children of agoraphobic parents. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 37 (4), 445-452.

Carter, B. (1993). Child sexual abuse: Impact on mothers. *Affilia*, 8(1). 72-90.

Cawson, P., Wattam, C., Brooker, S., & Kelly, G. (2000). Child Maltreatment in the United Kingdom: a Study of the Prevalence of Abuse and Neglect. Available from [http://www.nspcc.org.uk/Inform/publications/Downloads/childmaltreatmentintheUKexecsummary\\_wdf48006.pdf](http://www.nspcc.org.uk/Inform/publications/Downloads/childmaltreatmentintheUKexecsummary_wdf48006.pdf)

Cohen, J. (1988). *Statistical power analysis for the behavioural sciences*. (2<sup>nd</sup> ed.) Hillsdale, NJ: Lawrence Erlbaum Associates.

Cole, P. M., & Putnam, F. W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology*, 60, 174–184.

Coren, E. & Hutchfield, J. (2009a). *A meta-review of interventions to support children and their families in the aftermath of child sexual abuse*. Canterbury Christ Church University, Canterbury, UK. Available online: <http://www.actionforchildren.org.uk/uploads/media/29/9217.pdf>

Coren, E. & Hutchfield, J. (2009b). *Action for Children Child Outcomes-Focused Evaluation: Baseline Data Collection Report*. Canterbury Christ Church University, Canterbury, UK

Coren, E. & Hutchfield, J. (2009c). *General Evaluation Report Action for Children Safe and Secure Child Sexual Abuse Network* (report to funders) Canterbury Christ Church University, Canterbury, UK

Deblinger, E., Lippmann, J. & Steer, R. (1996). Sexually abused children suffering post-traumatic stress symptoms: initial treatment outcomes findings. *Child Maltreatment*, 1 (4), 310-321.

Department for Children, Schools & Families. (2008) 'Referrals, assessments and children and young people who are the subject of a child protection plan or are on child protection registers, England - year ending 31 March 2008, Table E. London: The Stationary Office. Available online from <http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000811/index.shtml>

Department for Education and Schools (2005). *Every Child Matters Outcomes Framework*. HM Government: London.

Department for Education and Schools (2006). Referrals, assessments and children and young people on child protection registers, England - year ending 31 March 2006. London.

Dominguez, R., Nelke, C., & Perry, B. (2006). Sexual abuse of children. American Academy of Experts in Traumatic Stress. Available online from <http://www.aets.org/article124.htm>

Ferguson, D.M., Horwood, L.J., & Lynskey, M.T. (1996) 'Childhood sexual abuse and psychiatric disorder in young adulthood: II. Psychiatric outcomes of child sexual abuse', *Journal of the American Academy of Child & Adolescent Psychiatry*, 35 (10), 1365-1374.

Goodman R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry*, 40, 791-801.

Goodman R., Meltzer H. & Bailey V. (1998). The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry*, 7, 125-130.

Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38, 581-586.

Gravetter, F.J. & Wallnau, L.B. (2009). *Statistics for the behavioral sciences*. 8<sup>th</sup> Edition. Belmont: Wadsworth.

Hetzel-Riggin, M. D., Brausch, A. M., & Montgomery, B. S. (2007) 'A meta-analytic investigation of therapy modality outcomes for sexually abused children and adolescents: An exploratory study', *Child Abuse & Neglect*, 31 (2), 125-141.

Hsu, L.M. (1995). Regression toward the mean associated with measurement error and the identification of improvement and deterioration in psychotherapy. *Journal of Consulting and Clinical Psychology*, 63(4), 141-144.

Jumper, S. A. (1995) 'A meta-analysis of the relationship of Child sexual abuse to adult psychological adjustment', *Child Abuse and Neglect*, 19 (6), 715-728.

Juster, H.R., Heimberg, R.G. & Engelberg, B. (1995). Self selection and sample selection in a treatment study of social phobia. *Behaviour research and therapy*, 33(3), 321-324.

Kazdin, A.E., Mazurick, J.L. & Bass, D. (1993). Risk for attrition in treatment of antisocial children and families. *Journal of Clinical Child Psychology*, 22, 2-16.

Kendall-Tackett, K.A., Williams, L.M. & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 113(1), 164 - 180.

Krause E.D. (2002). The Dodo bird verdict is alive and well – mostly. *Clinical Psychology: Science and Practice*, 9(1), 2-12.

Lambert, M.J. (1999). Are differential treatment effects inflated by researcher therapy allegiance? Could clever Hans count? *Clinical Psychology: Science and Practice*, 6(1), 127-130.

Ligezinska, M., Firestone, P., Manion, I. G., McIntyre, J., Ensom, R., & Wells, G. (1996). Children's emotional and behavioral reactions following the disclosure of extrafamilial sexual abuse: Initial effects. *Child Abuse & Neglect*, 20, 111–125.

Local Government Data Unit – Wales (2008) Child protection register statistics (Wales-2003-2004)'. Online. Available from <http://dissemination.dataunitwales.gov.uk>

Luborsky L., Rosenthal R., Diguer L., Andrusyna T.P., Berman J.S., Levitt J.T., Seligman D.A. & Krause, E.D. (2002). The dodo bird verdict is alive and well – mostly. *Clinical Psychology: Science and Practice*, 9 (1), 2-12.

- Luborsky, L., Diguier, L., Seligman, D.A., Rosenthal, R., Krause, E.D., Johnson, S., Halperin, G., Bishop, M., Berman, J.S., Schweizer, E. (1999). The researcher's own therapy allegiances: A "wild card" in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice*, 6(1), 95-106.
- Lynch, M. A., Glaser, D., Prior, V., & Wood. V. (1999). Following up children who have been abused: Ethical considerations for research design. *Child Psychology and Psychiatry Review*, 4(2), 68-75.
- Macdonald, G. M., Higgins, J. P. T. & Ramchandani, P. (2007). Cognitive-behavioural interventions for children who have been sexually abused. *Cochrane Database of Systematic Reviews*, 4
- McClellan, J., McCurry, C., Ronnei, M., Adams, J., Eisner, A., & Storck, M. (1996). Age of onset of sexual abuse: Relationship to sexually inappropriate behaviours. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34, 1375-1383.
- McNemar, Q. (1947). Note on the sampling of the difference between correlated proportions or percentages. *Psychometrika*, 12(2), 153-157.
- Mullen, P., Martin, J., Anderson, J., Romans, S., & Herbison, G. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: A community study. *Child Abuse & Neglect*, 20 (1), 7-21.
- National Society for the Prevention of Cruelty to Children (2010). More than 21,000 child sex offences recorded last year. Press release available online: [http://www.nspcc.org.uk/whatwedo/mediacentre/pressreleases/2010\\_25\\_january\\_more\\_than\\_2\\_1000\\_child\\_sex\\_offences\\_recorded\\_last\\_year\\_wdn70725.html](http://www.nspcc.org.uk/whatwedo/mediacentre/pressreleases/2010_25_january_more_than_2_1000_child_sex_offences_recorded_last_year_wdn70725.html)
- Paolucci, E., Genuis, M., Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology*, 135, 17–36.
- Prior, V., Lynch, M.A., & Glaser, D. (1994) *Messages from children: Children's evaluations of the professional response to child sexual abuse*. London: NCH Action For Children.
- Putnam, F. (2003). 'Ten-year research updates review: Child sexual abuse'. *Journal of the American Association of Child & Adolescent Psychiatry*, 42 (3), 269-278.
- Read, J. (1997) 'Child abuse and psychosis: A literature review and implications for professional practice', *Professional psychology: Research practice*, 28 (5), 448-456.
- Ribisl, K.M., Walton, M.A., Mowbray, C.T., Luke, D.A., Davidson, W.S. & Bootsmiller, B.J. (1996). Minimizing participant attrition in panel studies through the use of effective retention and tracking strategies: Review and recommendations. *Evaluation and Program Planning*, 19, 1-25.

Rosenthal, D. & Frank, J.D. (1956). Psychotherapy and the placebo effect. *Psychological Bulletin*, 53(4), 294-302.

Rutter, M. (1999) 'Resilience concepts and findings: Implications for family therapy', *Journal of Family Therapy*, 21, 119-144.

Shadish, W. R., Cook, T.D. & Campbell, D.T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Boston, New York: Houghton Mifflin.

Sheskin, D.J. (2000). *Handbook of parametric and non-parametric statistical procedures*. 2<sup>nd</sup> Edition. Chapman & Hall.

Skowron, E. & Reinemann, D. H. S. (2005) Effectiveness of Psychological Interventions for Child Maltreatment: A Meta-Analysis. *Psychotherapy: Theory, Research, Practice, Training*, 42 (1), 52-71.

Taylor, N. (2002) 'A transactional model for understanding the psychological sequelae of abuse: How asymptomatic and symptomatic child sexual abuse victims differ', *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 62, 5981.

Wonderlich, S.A., Brewerton, T.D., Jolic, Z., Dansky, B., & Abbott, D. (1997) 'Relationship of childhood sexual abuse and eating disorders', *Journal of the American Academy of Child and Adolescent Psychiatry*, 36 (8), 1107-1115.

Appendix 1.

**Child Outcomes Evaluation Follow-up**

THIS FORM SHOULD BE COMPLETED 12 MONTHS AFTER THE INITIAL ASSESSMENT OR AT CASE CLOSURE (WHICHEVER COMES FIRST).

Date of initial assessment \_\_\_\_\_

Reason for completion of follow-up: Case closed  12 months since assessment

Has the child changed living arrangements since assessment? Yes/No

If yes, how many times? \_\_\_\_\_

**Behaviour**

5a) Has the child/young person ever exhibited any sexually inappropriate behaviour? Yes/No

If yes, how many times (if any) has the child/young person done so in the past month? \_\_\_\_\_

If yes, but not within the last month please state how long ago (e.g., two months, one year, two years) and how frequently this behaviour occurred (e.g., daily, weekly, monthly, infrequently) \_\_\_\_\_

\_\_\_\_\_

5b) Has the child/young person ever exhibited any violent or aggressive behaviour? Yes/No

If yes, how many times (if any) has the child/young person done so in the past month? -

\_\_\_\_\_

If yes, but not within the last month please state how long ago (e.g., two months, one year, two years) and how frequently this behaviour occurred (e.g., daily, weekly, monthly, infrequently) \_\_\_\_\_

\_\_\_\_\_

5c) Has the child/ young person ever engaged in self harm? Yes/No

If yes, how many times (if any) has the child/young person done so in the past month? -

\_\_\_\_\_

If yes, but not within the last month please state how long ago (e.g., two months, one year, two years) and how frequently this behaviour occurred (e.g., daily, weekly, monthly, infrequently) \_\_\_\_\_

\_\_\_\_\_

5d) Has the child/ young person ever suffered from an eating disorder or related symptoms e.g. purging, binge eating, fasting, excessive exercise, laxative/diuretic use? Yes/No

If yes, how many times (if any) has the child/young person done so in the past month? -

\_\_\_\_\_

If **yes, but not within the last month** please state how long ago (e.g., two months, one year, two years) and how frequently this behaviour occurred (e.g., daily, weekly, monthly, infrequently) \_\_\_\_\_

---

## 6) Education

Does the child/young person regularly attend full educational provision appropriate to them?

Yes/No

How many times in the past week has the child/young person attended their school/educational provision/employment? (please give number of days attended out of number of days constituting full attendance, e.g., 3/5 ) \_\_\_/\_\_\_

## 7) Psychological health

7a) Please complete The Goodman Strength & Difficulties Questionnaire appropriate for child/young person's age (3 years or 4-16 years) with parent/carer.

**IMPORTANT: Please remember to write the case no (as in top right hand corner of this form) on the top of the Goodman Questionnaire.**

Is the person completing the Goodman Questionnaire is the same person who completed it at assessment? Yes/No

7b) How many times in the past week has the child/young person slept through the night?

\_\_\_\_\_

7c) How many times in the past week has the child/young person been known to wet the bed?

\_\_\_\_\_

7d) How many times in the past week has the child/young person been known to experience nightmares? \_\_\_\_\_

## 8) Other

8a) Is the child/young person currently taking any of the following medications? Ritalin   
Risperidone  Other (specify) \_\_\_\_\_

8b) Is the child/young person currently involved with CAMHS or any other therapeutic service?

Yes CAMHS  Yes other  (specify) \_\_\_\_\_ No

## Appendix 2.

### Strengths and Difficulties Questionnaire

P 3/4

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name .....

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often argumentative with adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can stop and think things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can be spiteful to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

## Strengths and Difficulties Questionnaire

P 4-16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name .....

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

### Interpreting Symptom Scores and Defining "Caseness" from Symptom Scores

Although SDQ scores can often be used as continuous variables, it is sometimes convenient to classify scores as normal, borderline and abnormal. Using the bandings shown below, an abnormal score on one or both of the total difficulties scores can be used to identify likely "cases" with mental health disorders. This is clearly only a rough-and-ready method for detecting disorders – combining information from SDQ symptom and impact scores from multiple informants is better, but still far from perfect. Approximately 10% of a community sample scores in the abnormal band on any given score, with a further 10% scoring in the borderline band. The exact proportions vary according to country, age and gender – normative SDQ data are available from the web site. You may want to adjust banding and caseness criteria for these characteristics, setting the threshold higher when avoiding false positives is of paramount importance, and setting the threshold lower when avoiding false negatives is more important.

	Normal	Borderline	Abnormal
<b>Parent Completed</b>			
Total Difficulties Score	0 - 13	14 - 16	17 - 40
Emotional Symptoms Score	0 - 3	4	5 - 10
Conduct Problems Score	0 - 2	3	4 - 10
Hyperactivity Score	0 - 5	6	7 - 10
Peer Problems Score	0 - 2	3	4 - 10
Prosocial Behaviour Score	6 - 10	5	0 - 4

	Normal	Borderline	Abnormal
<b>Teacher Completed</b>			
Total Difficulties Score	0 - 11	12 - 15	16 - 40
Emotional Symptoms Score	0 - 4	5	6 - 10
Conduct Problems Score	0 - 2	3	4 - 10
Hyperactivity Score	0 - 5	6	7 - 10
Peer Problems Score	0 - 3	4	5 - 10
Prosocial Behaviour Score	6 - 10	5	0 - 4

### Generating and Interpreting Impact Scores

When using a version of the SDQ that includes an "Impact Supplement", the items on overall distress and social impairment can be summed to generate an impact score that ranges from 0 to 10 for the parent-completed version and from 0-6 for the teacher-completed version.

	Not at all	Only a little	Quite a lot	A great deal
<b>Parent report</b>				
Difficulties upset or distress child	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2
<b>Teacher report</b>				
Difficulties upset or distress child	0	0	1	2
Interfere with PEER RELATIONSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2

Responses to the questions on chronicity and burden to others are not included in the impact score. When respondents have answered "no" to the first question on the impact supplement (i.e. when they do not perceive the child as having any emotional or behavioural difficulties), they are not asked to complete the questions on resultant distress or impairment; the impact score is automatically scored zero in these circumstances.

Although the impact scores can be used as continuous variables, it is sometimes convenient to classify them as normal, borderline or abnormal: a total impact score of 2 or more is abnormal; a score of 1 is borderline; and a score of 0 is normal.

## Appendix 3. SDQ Scales

### Emotional Symptoms Scale

Somatic symptoms, worries, sadness or depression, anxiety, fear and insecure attachment behaviours.

### Conduct Problems Scale

Temper, obedience, fighting/bullying, lying/cheating, and stealing

### Hyperactivity subscale

Restless/overactive, fidgeting, distraction/wandering concentration, thinking before actions, and completion of tasks/attention span

### Peer Problems Scale

Solitary, at least one good friend, liked by other children, picked on/bullied, gets on with adults better than children

### Prosocial Scale

Considerate of others feelings, shares readily, helpful if someone is hurt or ill, kind to younger children, volunteers to help others