Child abuse and neglect

Consultation on draft guideline
Stakeholder comments table

22 February 2017-19 April 2017

Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association of Paediatric Psychotherapists	Full and short	General	general	Question 1: **Which areas will have the biggest impact on practice and be challenging to implement?** The document shows a full understanding of the range of complex issues – ones which may need to be communicated, understood and acted on in relation to child abuse and neglect. However, one of the biggest challenges we are concerned about, is that this flexible, empathic and age appropriately recommended approach is often not possible to implement in services where there is a distinct lack of well trained specialists able to manage the high level of anxiety and vicarious trauma potentially experienced through working closely with children, young people and families where significant trauma and abuse has occurred. The priority in many CAMHS teams, to meet waiting list targets and fulfil the expectations of commissioners with funding cuts, has lead to a greater emphasis on shorter-term interventions which can also easier to measure and ensures higher throughput. However as the guideline points out, allowing space for a child or young person to develop significant trust in a professional, requires time and an approach which establishes a secure attachment focused model and one which can adapt to the "well assessed" needs of the child, family and professional network supporting them. We would like to see more emphasis (**Planning and Delivering Services**) on having access to a range of therapeutic specialists within CAMHS to treat and manage the level of disturbance, co-morbidity and complexity associated with these cases. This relates to the training of the Mental health specialist workforce and is also particularly relevant in relation to causing possible prejudice to any formal investigations and achieving best evidence.	Thank you for your comment. The guideline committee recognised the constraints on resources. In developing the recommendations, the committee took in to consideration cost effectiveness evidence and economic modelling data where available, aiming to ensure that the recommendations represent an effective use of local resources. They considered the recommendations aspirational but achievable. It is not usual for NICE guidance to make recommendations about staffing levels required to achieve the recommendations. However, we will pass your comments relating to planning and delivering services to our implementation colleagues.
Association of Paediatric Psychotherapists	Short	general	general	Question 2: **Would implementation of any of the draft recommendations have significant cost implications?** We think that there are greater cost implications for Trusts, CCGs and ultimately the Government, in **not** providing well resourced multi-disciplinary and multi-professional services for children and young people reflected on in the draft guideline - where professionals are trained and supported to work together to use reflective practice and to *think critically and analytically about cases and not relying solely on protocols, proformas and electronic recording systems to support … professional thinking and planning.* There would, we think, be a cost implication to ensuring that higher banded and well trained (post graduate NHS based trainings) specialists are retained in the NHS and children's services workforce, but a wiser and more sustainable economy where the rest of the workforce would be better contained and supervised. The ACP can provide concrete examples of good practice working across services to encourage critical and analytic thinking around the more complex and risky cases. Please let us know if this kind of evidence and information would be useful.	Thank you for your comment. The guideline committee considered carefully the resource impact of the recommendations, including use of economic evaluation and modelling evidence where available. The committee's view was also that investment in the interventions recommended here would lead to savings elsewhere in the system.
Association of Paediatric Psychotherapists	Short	general	general	Question 3: **What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** The ACP is concerned that many community projects where resources were available to vulnerable families, young parents and children etc, such as the family Nurse Partnership, family centres and youth service centres have been closed or have had resources cut. This has left many families and children experiencing abuse and neglect going unnoticed for longer and not being supported early enough in the life of the problem or difficulty. Our members also report an increasing level of "emotional poverty" amongst families who have little access to services and can become "invisible" to overstretched services, when children drop out of nursery or school. We would support wider access to specialists who could provide supervision to social workers and health visitors and introduce more a capacity to think about and notice the "invisible" cases highlighted in high profile child death cases. We would also advocate closer links between health, education and social care – not only providing school counselling as the government has	Thank you for your comment. The guideline committee considered carefully the resource impact of the recommendations, including use of economic evaluation and modelling evidence where available. The committee were also concerned about widespread cuts to services, and hoped that the recommendations of this guideline may advocate against decommissioning of evidence-based services. The provision of

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				advocated, but with a more sophisticated process of using professional consultation to encourage open discussion and shared planning such as happens with the children's panel in Scotland. We can also give examples of good practice in this area.	therapeutic interventions is also highlighted as an issue in the implementation section of the guideline. Multi-agency planning arrangements are outlined in Working Together 2015 so have not been covered in this guideline.
The Association of Directors of Children's Services (ADCS)	Short	General	general	The Association of Directors of Children's Services Ltd (ADCS) welcomes the opportunity to comment on the draft National Institute of Clinical Excellence (NICE) child abuse and neglect guideline. ADCS is the professional leadership association representing directors of children's services and their senior management teams in local authorities across England. This document should be read as an official response to the NICE consultation. A supporting appendix accompanies this submission. Where comments refer to specific paragraphs or sections in the draft document, this is indicated for convenience. NICE was tasked by the Departments for Education and Health in 2014 to produce a guideline on abuse and neglect for professionals working with children and young people across schools and early years, social care, medical centres and custodial settings. It encompasses physical, emotional and sexual abuse, including sexual exploitation, child trafficking and forced marriage, as well as neglect. Given the scope, size and complexity of the topic, this group of practitioners is plainly too broad. Even within the remit of children's services, the needs of the workforce differ greatly depending on levels of contact with children and the significance within individual roles of work with those who have been abused and/or neglected. While advice on recognition is applicable to all practitioners, information on assessment is only relevant to those with more specialist roles. These guidelines would be more user friendly if organised to reflect these differences and/or broken down into a series of 'bite sized' guides. There seems to be little recognition that the standard NICE methodology of identifying questions, undertaking a literature review and forming guidelines based on the resulting evidence is not suited to the task in hand. Sadly, the draft guidelines are not well grounded in the significant amount of guidance and good practice advice that already exists in this highly-contested area of policy and practice. More could, and should, be done to build on sources practitioners are familiar with, most notably Working Together. The various versions of Working Together, particularly the 2010 iteration, covers good practice in working with vulnerable children and young people including the identification of abuse and neglect, principles for working with children and families and much, much more. At 581 pages, plus several supporting annexes, this guidance is overly long - between 2010 and 2013, Working Together was streamlined from 700+ pages to 100 or so in an effort to make it more accessible to frontline practitioners. In addition to Working Together, approximately 50 statutory and/or practice guidance notes from the Departments of Education and Health, the Ministry of Justice, the Home Office, the Foreign and Commonwealth Office plus Public Health England, the General Medical Council and others (including NICE) are in circulation. They deal with everything from general child protection principles to responses to specific safeguarding issues, including trafficking, domestic violence, female genital mutilation, sexual exploitation and forced marriage. It is obvious that a great deal of work has gone into producing this guideline, however, in its current form, it is difficult to see how it can have a significant impact on practice. The literature review is extensive yet the limitations of the evidence base used, much of which is drawn from the United States, is not recognised. Similarly, the guideline does not seek to address this deficit via the use of wider expert opinions. This is a missed opportunity and could have added value to this work - there is a dearth of research around perpetration, for example. Greater clarity is needed about who exactly the guideline is for and further consideration should be given to the ways in which practitioners might use it. ADCS would welcome a clearer focus on the centrality of relationships in work with children and families, better contextualisation of the recommendations, including how they relate to existing guidance, and recognition given to the resource constraints on all agencies working with children. Greater weight should also be given to UK-interventions which are more readily accessible to practitioners and commissioners in the final version of the guidelines. Finally, it is worth keeping in mind that the Department for Education is about to begin a review of Working Together in light of wide ranging plans and developments included in the Children and Social Work Bill (CSWB). Similarly, the outcome of the government's consultation on the mandatory reporting of abuse and neglect is still awaited and should be factored in here once available.	Thank you for your comment. The role and remit of NICE is to develop evidence-based guidance, and this guideline has been developed based on the methods in the NICE manual. However, we were cognisant of the nature of the social care evidence base and aimed to capture relevant evidence, whilst operating within the NICE methodology. These included: a) Developing a series of review questions relating to 'aspects of professional practice'. These questions sought to explore professional practices which did not fit easily within the concept of 'an intervention'. b) Developing a review question about organisational factors supporting effective practice. c) Inclusion of review questions on the views and experiences of children and young people, parents and practitioners. We have now clarified the audiences for the guideline, and also the different audiences for each section of the guideline. The introduction to the guideline also clarifies the relationship of this guideline with Working Together 2015 and other guidance. These are cross-referenced in the introduction to relevant sections, and in specific recommendations as appropriate. The guideline also makes reference to the list of existing guidance available in Appendices B and C of Working Together. With regard to the use of US evidence, the inclusion of US evidence within the review protocol was agreed with the guideline committee at the outset. The committee were keen that the evidence should be of the highest quality, including learning from best practice from other countries. Consideration was given throughout the process to the applicability of this evidence and relevance to approaches used in the UK. Expert opinion was sought in relation to forced marriage, child sexual exploitation, FGM and child trafficking. With regard to centrality of relationships, recommendations 1.1.1 to 1.1.11 make

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					recommendations about how to build effective working relationships with children, young people, parents and carers. Recommendations 1.5.1, 1.5.2, 1.5.3, 1.7.1, 1.7.2 and 1.7.3 also emphasise the importance of engaging in dialogue with children, young people and families regarding any support and interventions, and offering any interventions based on clear assessment. There is a shorter version of the guideline (54 pages) which is the version NICE would expect practitioners to refer to. The longer version provides details of all the evidence reviewed and committee discussion for those wishing to know more. A shorter 'quick guide' for professionals will also be produced. NICE has also developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance. Thank you for bringing to our attention the work to update Working Together. NICE is in discussion with the Department of Education regarding how to co-ordinate with this work.
The Association of Directors of Children's Services (ADCS)	Short	7 - 9		The draft does not seem to deal with the application of this guidance into practice e.g. in section (1.2) on recognising abuse and neglect, several lists of 'symptoms' are offered without any development of how these might be used. The section on telling others about abuse and neglect (1.2.1) does not sufficiently recognise the centrality of trusting relationships in the disclosure of abuse, particularly sexual abuse, by children and young people. One study by the vein 2013 found that disclosure was delayed on average by 7.8 years from the start of the abuse. It would be helpful if this was addressed in the guidance via greater emphasis on developing relationships with key workers/professionals. Some of the behavioural indicators of neglect (1.2.25-27) seem overly simplistic and leave little room for the consideration of factors outside of the parent/carers immediate control e.g. poor quality housing, insecure employment, benefit sanctions etc. It is noted in passing that professionals may find it difficult to distinguish between neglect and material poverty, if, for example, a child is "dirty and smelly." In (1.2.9) the list of parental risk factors for abuse and neglect is broad and lacks enough detail to be of value to practitioners who suspect a child's welfare is at risk.	Thank you for your comment. We have now added further detail at the beginning of the section on alerting features regarding the actions that practitioners should take if they observe the alerting features described. With regard to parental risk factors for abuse and neglect, introductory text has been added to this section to clarify that these should be considered in conjunction with the alerting features set out in Section 1.3. Recommendations 1.1.1 to 1.1.9 relate to building up effective relationships with children and young people. Recommendations 1.3.1 to 1.3.8 also refer to factors that can help or hinder children and young people to disclose abuse and neglect, and how practitioners should work in those situations. Recommendation 1.2.2 was drafted based on GC consensus following consultation feedback and refers to environmental vulnerability factors for abuse and neglect, including poverty poor housing. The Allnock and Miller (2013) paper was included in the evidence review for the guideline, and contributed to recommendations about how professionals should work with children when they tell them that abuse has occurred.
The Association of Directors	Short	17 - 19		In the assessment section (1.3), there is little or no or reference to the existing assessment guidance for social workers	Thank you for your comment. We have

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of Children's Services (ADCS)				(or indeed guidance for other professionals), to assessment tools, planning interventions or reviewing impact. This is surprising. If little evidence was found in the literature search, best practice advice from experts would be a helpful addition here. The lists of characteristics would be more useful to practitioners if supplied alongside an analytical framework or if weightings were attached to specific risk factors.	now made clearer that practitioners should refer to guidance on early help and statutory assessment in Chapter 1 of Working together to safeguard children as well as local protocols for assessment. As such, we would expect practitioners to use the Assessment Framework as their analytical framework, in line with statutory guidance. We searched for evidence on assessment tools, but did not find any studies which met our criteria.. However, the guideline has also drawn on expert advice from expert witnesses, committee members and an expert reference group of children and young people.
The Association of Directors of Children's Services (ADCS)	Short	19 - 20		Early help (1.4.1) refers to home visiting programmes without naming any specifics yet the section on parenting does identify specific programmes which is more helpful. (1.4.9) says: "Consider a planned activities training programme, with or without mobile phone support, for vulnerable mothers… of pre-school children," who is this aimed at, which programme, what does the research say about its content?	Thank you for your comment. We have now provided an example in recommendation 1.5.13 of one of the effective home visiting programmes for which we found evidence. Recommendation 1.4.9 (now 1.5.10) has been amended to give more detail about who this should be aimed at, and the content of the intervention.
The Association of Directors of Children's Services (ADCS)	Short	22 – 23		Responses and support for children and young people after abuse (1.5.3), who is this list of actions aimed at? Why is the domestic violence section only addressed at the police (1.5.4)? (1.5.5) Why are the suggested responses listed here e.g. provide safe accommodation, only about child trafficking?	Thank you for your comment. Recommendation 1.5.3 (now 1.6.2) has been amended to make it clearer that this recommendation is aimed at all practitioners supporting children and young people who have been assessed as being 'in need' or at risk of significant harm in relation to abuse or neglect, with leadership and coordination by the social worker. We have amended the recommendations related to domestic violence to cross-reference to the relevant NICE guideline. Similarly, we have amended the recommendation on child trafficking to direct professionals to follow the guidance in Safeguarding children who may have been trafficked.
The Association of Directors of Children's Services (ADCS)	Short	23 - 27		It is unclear why the therapeutic interventions for children, young people and families after abuse and neglect (1.6) deals with children living in the family home or with foster carers but not in residential care settings, including children's homes and supported lodgings. Who are the recommendations on therapeutic interventions (1.6.4) addressed to and which attachment based interventions does the guideline refer to? Where is parent child psychotherapy available (1.6.6), what are the benefits or successes of this pathway? Has the NHS ever commissioned this in England? It is unclear who the therapeutic suggestions listed in (1.6.8) are aimed at - from a practitioner/commissioner perspective some discussion of availability, cost etc. would be both relevant and welcome. It is unclear why the guidelines refer only to girls who have been sexually abused and who are showing signs of emotional or behavioural disturbance (1.6.17). A 2014 study by Barnardo's suggested that 33% of referrals to CSE services involved boys and young men.	Thank you for your comment. There is an existing NICE guideline on services to support the health and wellbeing of looked after children, which includes recommendations relating to provision of residential care. Our recommendations therefore do not cover therapeutic residential placements. Our recommendations aimed to focus on interventions rather than therapeutic placements. The evidence we reviewed included some inteventions delivered 'via' a foster carer or adoptive parent. Interventions provided directly to children and young people (for example trauma-focused CBT) could still be provided to children and young people in residential settings. We have now included introductory text to this section (now 1.7) making it clearer that these interventions are aimed at strategic commissioners of services for children who

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					have been abused or neglected; social workers and others co-ordinating support for children and young people, to help them decide what services to refer children and young people to; and child and adolescent mental health practitioners (psychologists, psychotherapists, psychiatrists), professionals in specialist family intervention teams (for example social workers) and voluntary sector agencies. We have made reference in recommendation 1.7.4 to an example of a specific attachment-based interventions for which we found evidence (attachment and biobehavioural catch-up). With regard to availability of interventions, the committee discussed the extent to which these interventions were available, drawing on expertise from social care and CAMHS within the group. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Most recommendations are worded as 'consider', meaning that practitioners should think about providing the intervention, rather than that they must offer it. With regard to parent-child psychotherapy it was the view of the committee that interventions of this type were available through CAMHS. For therapeutic interventions following sexual abuse, the guideline suggests three possible interventions, of which two have been shown to be effective for both girls and boys. The intervention recommended for girls only (now recommendation 1.7.19) is because the underpinning research had been conducted with girls only, and the committee did not think it was appropriate to extrapolate this to boys.
The Association of Directors of Children's Services (ADCS)	Short	28		The 'planning and delivery' section (1.7.3) references 'less well-recognised forms of abuse, including child sexual exploitation (CSE), female genital mutilation (FGM), forced marriage and child trafficking,' this might be better phrased as 'emerging and evolving threats,' as the sector's knowledge and understanding of these risks has increased significantly since the guideline was originally commissioned. However, the guideline is largely silent on the signs and symptoms of online grooming and exploitation which is a growing issue, as is radicalisation. ADCS members highlighted the lack of focus on schools as a particular concern given their vital role in the early identification of issues and the provision of support to children and their families – they are the eyes and ears of children's social care.	Thank you for your comment. We have rephrased this recommendation as 'other' forms of abuse to acknowledge that knowledge of these forms of abuse has increased significantly. Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, including where recommendations are relevant to education and schools professionals.

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					We found no empirical evidence that met our criteria in relation to online grooming and exploitation. The guideline committee have made a research recommendation on this topic.
The Association of Directors of Children's Services (ADCS)	Short	29 - 33		Terms used in this guidance (page 29 onwards) - the Home Office published an updated definition of CSE earlier this year, it would be helpful if the final guideline reflected this to avoid any confusion. Similarly, reporting of suspected FGM cases is now mandatory, again, it would be helpful if this was reflected here. The definition of 'parent or carer' does not seem to recognise the status of adopters and the definition of foster carers seems to explain their status largely in monetary terms, this is unhelpful.	Thank you for your comment. We have now included the updated definition of child sexual exploitation in the 'Terms used in this guideline' section. The definition of parent and carer has now been updated to include reference to adoptive parents, and the definition of foster carers has been redrafted. We have now made reference to mandatory reporting of FGM in recommendation 1.3.8.
The Association of Directors of Children's Services (ADCS)	Short	33 - 36		The planning and delivery of services is dealt with in Working Together and sits within the remit of multi-agency safeguarding arrangements (currently LSCBs).	Thank you for your comment. We have added introductory text at the beginning of this section cross-referencing to the relevant content in Working Together 2015.
The Association of Directors of Children's Services (ADCS)	Short	36 - 38		The context section (page 36 onwards) seems to omit reference to several key changes in the design and delivery of children's services. Local safeguarding children boards (LSCBs) are referenced as are serious case reviews (SCRs), yet under the CSWB, which is expected to receive royal assent in the coming weeks, neither will exist in the future. Further, the CSWB will put sex and relationships education on a statutory footing for the first time. Equipping children and young people with knowledge and courage to recognise the signs of abuse should be central to prevention. It is important that national guidance of any kind is responsive to legislative and policy changes. The pace and scale of change in children's services in recent years is significant, see here and here.	Thank you for your comment. As the Children and Social Work Act has now received royal assent, this section has now been amended to include this. The terms used in the guideline have also been amended to reflect the changes in the Act.
The Association of Directors of Children's Services (ADCS)	Short	39		The recommendations for further research are helpful and would sit well with a section which considers the current weaknesses and limitations of the evidence.	Thank you for your comment. The rationale for each research recommendation aims to show how the limitations of the evidence base have prompted the recommendation.
Adfam	Short version and appendices	General	General	It is disappointing that the guideline makes scant – and inexplicit reference to the role parental substance misuse plays in child neglect. It is noted that no evidence papers on this topic were reviewed, and no –one with any specific experience of substance misuse was a committee member. Parental substance misuse is a major cause of child neglect and to omit it from this guidance diminishes its robustness and quality. Children living in families affected by parental problem drug *use are at significant increased risk of poor developmental outcomes and child maltreatment (particularly neglect in all aspects), and they are also more likely to develop problems with substance use themselves and experience poor outcomes that persist into adulthood e.g. poor school achievement, poor self-esteem, difficulties in making friends*. (ACMD 2003, Cleaver et al 2011). *It is well established that PSM is a significant feature of social welfare professionals' caseloads – with neglect and emotional and physical abuse the most common concerns for children who are subject to child protection plans. It is also one of the 'toxic trio', often co-existing with domestic violence and mental health problems (*Forrester and Harwin, 2011; Brandon et al, 2010). Cleaver et al (2011)	Thank you for your comment. We recognise that parental substance misuse is a significant issue. We reviewed evidence on parental substance misuse as a vulnerability factor for abuse and neglect (Stith et al. 2009) and also several interventions specifically aimed at parents with substance misuse difficulties. We have included reference to parental substance misuse in section 1.3.6 on 'Parental vulnerability factors', and in 1.5.10 and 1.5.11 on Parenting Programmes. With regard to the studies you have suggested: • Our review protocols include studies post-2004 only. A date cut-off is used to limit the volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal framework for how social services and other agencies deal with issues relating to children. Hence ACMD (2003) could not be included • Our review protocols also precluded the inclusion of books, hence Forrester and Harwin (2011) and Cleaver and Unnell 2011) were not

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					included
Association for Dance Movement Psychotherapy	Short	27	15	1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. We would be grateful if Dance Movement Psychotherapy can be included under "Creative approaches (such as drama or art) on line 15 page 27 of the short version of this draft consultation. Many experienced Dance Movement Psychotherapists are working effectively within children's services and Dance Movement Psychotherapy is a holistic approach that is developing an evidence base. Some examples are listed below. Dance movement psychotherapists are qualified practitioners, trained for a minimum of three years at a Masters' level. Qualified dance movement psychotherapists emphasise the non-verbal and creative aspects of relating within an agreed and safe relationship. **Case studies on dance movement psychotherapy and adoption** Harvey, S. (1995) Sandra: The Case of an Adopted Sexually Abused Child. Levy, F (1995) Dance and Other Expressive Arts Therapies: When Words are Not Enough. Routledge: USA. Chapter 12 p. 167- 180 Blau, B and Reicher, D (1995) Early Intervention with Children at Risk for Attachment Disorders. In Levy, F (1995) Dance and Other Expressive Arts Therapies: When Words are Not Enough. Routledge: USA. Chapter 13 p.181 - 189 **Working with teaching staff:** Karkou, V. Fullarton, A. and Scarth, S. (2010) Finding a Way out of the Labyrinth through Dance Movement Psychotherapy: Collaborative Work in a Mental Health Promotion Programme for Secondary Schools. In V Karkou(ed) Arts Therapies in Schools: Research and Practice. London: Jessica Kingsley, 59-84. This programme in the first instance, offered training to teaching staff on identifying and understanding signs of emotional distress. This is just one example available in the published literature. **Working with families:** Loman, S. (1998) Employing a Developmental Model of Movement Patternsin Dance/Movement Therapy with Young Children and Their Families. American Journal of Dance Therapy. Vol 20. No 2,Fall/Winter1998 Weston, C. (2015) Becoming bonded through Developmental Movement Play: review of a parent and child movement group incorporating the theory, practice and philosophy of Sherborne Developmental Movement. Body, Movement and Dance in Psychotherapy. Volume 10, Issue 4, pages 189-193 Desmarais, S. (2006) `A space to float with someone`: recovering play as a field of repair in work with parents of late-adopted children. Journal of Child Psychotherapy. Vol. 32 No. 3 2006 349 – 364 **Dance Movement Psychotherapy in schools** Eke, L. & Gent, A.M. 2010, "Working with withdrawn adolescents as a moving experience: A community resourced project exploring the usefulness of group dance movement psychotherapy within a school setting", Body, Movement and Dance in Psychotherapy, vol. 5, no. 1, pp. 45-57. Tortora S (2005) The dancing Dialogue: Using the Communicative Power of Movement with Young Children. MN: Redleaf Press Tortora, S (2010) From the Dance Studio to the Classroom: Translating the Clinical Dance Movement Psychotherapy Experience into a School Context. In V Karkou (ed) *Arts Therapies in School: Research and Practice*. London: Jessica Kingsley, 27-43. Koshland, L (2010) Peace through Dance Movement Therapy: The Development and Evaluation of a Violence Prevention Programme in an Elementary School. In V Karkou (ed) *Arts Therapies in Schools: Research and Practice*. London: Jessica Kingsley, 43-58. Kosland, L and Whittaker, J B (2004) Peace through Dance/Movement Therapy: A violence prevention programme for elementary school, *American Journal pf Dance Therapy*, 26, 2, 69-90. **Dance Movement Psychotherapy with Children with emotional and/or behavioural difficulties:** Meekums B (2008) Developing emotional literacy through individual Dance Movement Therapy: a pilot study, *Emotional*	Thank you for your comment. We have reviewed the studies you have suggested. We have been unable to include them because: - Our review protocols includes studies post-2004 only. A date cut-off is used to limit the volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal framework for how social services and other agencies deal with issues relating to children. Hence the studies you have suggested from before that date could not be considered. - The more recent studies you have suggested on the effectiveness of dance therapies, did not from a reading of the title and abstracts appear to deal with their effectiveness for supporting and assisting children and young people who have experienced or are at risk of abuse and neglect. They therefore do not meet our inclusion criteria.

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				and Behavioural Difficulties Vol. 13, No. 2, 95–110 Payne, H (1987) The perceptions of male adolescents labelled delinquent towards a programme of dance movement therapy, MPhil thesis, University of Manchester. Payne, H. (1992) 'Shut in, Shut out: Dance Movement Therapy with Children and Adolescents.' In H. Payne (ed.) *Dance Movement Therapy: Theory and Practice*. London: Routledge, 39–80. Ylönen, M.E. & Cantell, M.H. 2009, "Kinaesthetic narratives: Interpretations for children's dance movement therapy process", *Body, Movement and Dance in Psychotherapy,* vol. 4, no. 3, pp. 215-230. **Systematic Literature Reviews:** Strassel,J.K., Cherkin, D. C., Steuten, L., Sherman,K.J., & Vrijhoef, H.J.M.(2011). A systematic review of the evidence for the effectiveness of dance therapy. Alternative Therapies in Health & Medicine, 17(3), 50–59. **Neuroscientific research, dance movement psychotherapy and relationships** Within dance movement psychotherapy, the following empirical studies offer evidence on the impact of kinaesthetic empathy on the brain: Rova, M. (2012-2015) Embodying Kinaesthetic Empathy as an Intersubjective Phenomenon and Clinical Intervention: a practice-based interdisciplinary study combining Dance Movement Psychotherapy, Phenomenology and Cognitive Neuroscience. London: University of Roehampton (PhD research) Fischman, D. (2009) Therapeutic Relationships and Kinesthetic Empathy in Chaiklin, S. & Wengrower, H. (Eds.). The Art and Science of Dance/Movement Therapy: Life is Dance. New York/London: Routledge http://www.torontopubliclibrary.ca/detail.jsp?R=2681347 McGarry, M. L. & Russo, F.A. (2011) Mirroring in dance/movement therapy: Potential mechanisms behind empathy enhancement. The Arts in Psychotherapy, 38, 178-184 http://www.sciencedirect.com/science/article/pii/S0197455611000426 Beausoleil, E. & LeBaron, M. (2013), "What Moves Us: Dance and Neuroscience Implications for Conflict Approaches: What Moves Us", Conflict Resolution Quarterly,vol. 31, no. 2, pp. 133-158. Fonagy, P. & Target, M. (2007), "The Rooting of the Mind in the Body: New Links Between Attachment Theory and Psychoanalytic Thought", Journal of the American Psychoanalytic Association, vol. 55, no. 2, pp. 411-456. **Neuroscientific research** The role of embodiment within psychotherapy is currently receiving renewed attention from neuroscientists. For example, research studies in neuroscience provide evidence for the biological basis of emotion and the links between body and feelings (Damasio 1994, 2000); the plasticity of the brain and thus a life-long ability for humans to make new synaptic connections (Edelman 1987); the role of mirror neurons in the brain and their links with empathy (Rizzolatti et al 1996; Gallese 2003; Gazzola et al 2006). **Cochrane Systematic Review:** Meekums B, Karkou V, Nelson EA. Dance movement therapy for depression.Cochrane Database of Systematic Reviews 2015, Issue 2. Art. No.: CD009895. DOI: 10.1002/14651858.CD009895.pub2. The review recommended the need for further research. http://onlinelibrary.wiley.com/doi/10.1002/14651858. CD009895.pub2/abstract **Meta-analyses:** Koch S, Kunz T, Lykou S and Cruz R (2014) Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis, The Arts in Psychotherapy, 41, 46-64.	

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				http://www.sciencedirect.com/science/ article/pii/S0197455613001676 **Randomized controlled trial** Bräuninger, I. (2012) Dance movement therapy group intervention in stress treatment: A randomized controlled trial (RCT) The Arts in Psychotherapy Volume 39, Issue 5, November 2012, Pages 443–450 Jeong Y J and Hong, S C (2005) Dance Movement Therapy Improves Emotional Responses and Modulates Neurohormones in Adolescents with Mild Depression, International Journal of Neuroscience, 115:1711–1720	
Association for Dance Movement Psychotherapy	Short	27	15	2. Would implementation of any of the draft recommendations have significant cost implications? Offering Dance Movement Psychotherapy as part of a whole person care approach for children as an early intervention could reduce the long term costs in relation to supporting adults who continue to have mental health issues following abuse and neglect during their childhood. Therefore the proactive approach rather than reactive approach to care and support could save money in the longer term and reduce the individual's needs to continue needing support as an adult.	Thank you for your comment. The Guideline Committee took advice from an economist throughout the process of producing guidelines, with the economic methodology outlined in Appendix C. Where economic data was included in a study, this was taken into account in recommending interventions. However, we wold be unable to recommend as being cost effective the treatment you have proposed without data to support this.
Association of Directors of Public Health	Full	General	general	The guideline is very thorough and comprehensible. The main concern raised by Directors of Public Health is the practicality of the guideline to be used as a tool. The guideline is very detailed therefore might not be helpful to professionals. It would be much more helpful to have a summary that professionals can read and use as a checklist.	Thank you for your comment. We have taken steps in response to comments to ensure that the structure of the guideline is now more accessible, with clear indications of which sections are applicable to which practitioners. A concise 'quick guide' for practitioners will also be produced. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
The Association for Family Therapy and Systemic Practice in the UK	Short	1	Section: 'Who is it for?'	It is identified in a later section (Parental risk factors for abuse and neglect, page 9, lines 6 to 9) that parental risk factors for abuse and neglect can include: substance misuse difficulties; history of domestic abuse; showing emotionally volatility or problems managing anger; and experiencing mental health problems. I am writing this from the perspective of a clinical psychologist and systemic family therapist working in adult mental health services. These guidelines also need to be for practitioners working in adult mental health, substance abuse services and those providing input around domestic abuse. Practitioners in adult mental health and substance abuse services for example need to be aware of these guidelines, and may well be part of the child protection network and / or providing part of the therapeutic input, for example, therapy with a parent or carer, or family therapy and family interventions. (If some roles are only for practitioners who work in services for children, rather than adult mental health or substance abuse for example, this needs to be made explicit.) Practitioners in adult mental health services may also observe parent child interactions during home visits.	Thank you for your comment. The introductory text at the beginning of section 1.1 now makes it clearer that sections 1.1 to 1.3 are also relevant to those working in adult services.
The Association for Family Therapy and Systemic Practice in the UK	Short	6	21 to 22	"avoiding blame, even if parents may be responsible for the abuse and neglect" AFT appreciates it is difficult to convey in a sentence the wish and need to build a good working relationship with parents and carers; acknowledgement that parents and carers may be responsible for abuse; and acknowledgement that parents and carers may have difficult circumstances such as mental health problems. However, there needs to be a transparency also that whilst parents may have mental health problems, for example, they need to take responsibility for safety. Perhaps the sentence could be something like "avoiding blame, even if parents may be responsible for the abuse and neglect, whilst working towards helping parents to take responsibility for safety"	Thank you for your comment. We agree that it is difficult to convey this balance. Our view is that the concept of encouraging parents to take responsibility is covered in 1.1.13 'being clear about the issues and concerns that have led to your involvement.'
The Association for Family Therapy and Systemic	Short	19	3 to 7	The guideline later gives a definition of 'parent' and 'carer' (page 32, lines 14 to 19), but it may be helpful here to also refer to any wider network of carers for the child, as a reminder to not solely focus assessment on the immediate family.	Thank you for your comment. The recommendation has been amended to

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Practice in the UK				For example - address both the …. of parents and carers, including any carers who may be in the wider network around the family, and acknowledge..	make reference to the wider family network.
The Association for Family Therapy and Systemic Practice in the UK	Short	22	4 to 13	AFT welcomes the focus in this section on the need for practitioners working across agencies to work together with families in which a child is involved in statutory child protection processes. The recommendation to have an initial meeting with relevant practitioners to agree roles, responsibilities, and ways of working is particularly helpful. It may be helpful to make a separate recommendation to share information, to highlight the standalone value of the recommendation to agree roles etc.	Thank you for your comment. This section has been reviewed to reduce duplication with Working Together 2015. We have not made specific recommendations on information sharing as there is existing guidance in Information sharing advice for safeguarding practitioners.
The Association for Family Therapy and Systemic Practice in the UK	Short	27	Line 7 Line 27	Re Therapeutic interventions for children, young people and families after sexual abuse Section 1.6.15 re group or individual trauma focused CBT, and Section 1.6.17 re individually focused psychoanalytic therapy or group psychotherapeutic and psycho-educational sessions, both include a recommendation to Section 1.6.15: provide separate sessions for the non-abusing parent or carer Section 1.6.17 provide separate sessions for the non-abusing parent or carer In my experience of providing systemic family therapy whilst another practitioner provides individual therapy for a service user, this works well when: - there is a shared formulation - the therapists talk about how the work is going and consider how well the focuses of the family and individual interventions are fitting together - the service user and family are aware the therapists think together about the work Running two therapeutic interventions alongside conversely works less well when the therapists have different formulations and / or the communication is more difficult. It may be helpful in this guideline to recommend how the interventions for the child or young person and the sessions for the non-abusing parent are anticipated to work alongside each other, and the extent to which information sharing may be helpful across the therapists or practitioners in the context of working with children who have been abused.	Thank you for your comment. The evidence we reviewed did not include any information about interaction between the therapist working with the child and the therapist working with the parent/family. We have therefore not made recommendations in this area.
The Association for Family Therapy and Systemic Practice in the UK	Short	Page 27 To Page 29	Line 27 Line 2	Planning and delivering services It is important for the staff and agencies around the child and family to be working well together. This goes beyond sharing information, to being able to address any problems in communication openly, and to sharing responsibility for working well together for the benefit of the child (as central) and the family. A system that is not working well and has problems with communication will be less able to help a family with their difficulties, and will be less able to model helpful communication and problem solving including finding resolution when there are difficulties in relationships. A systemic perspective is helpful here.	Thank you for your comment. We agree that a systemic perspective is helpful. This is encouraged in a range of existing guidance including Working Together 2015 and Information sharing advice for safeguarding pracititoners. Reference to these documents is made in the guideline.
The Association for Family Therapy and Systemic Practice in the UK	Short	26		Therapeutic interventions for children, young people and families after sexual abuse. AFT would like to bring the following resources to the attention of NICE. Turnell, A, and Essex, S. (2006) Working with 'denied' child abuse: the resolutions approach. Open University Press http://www.signsofsafety.net/working-with-denied-child-abuse/ http://www.signsofsafety.net/research/	Thank you for your comment, and for drawing our attention to resources for therapeutic interventions for children, young people and families after sexual abuse. The resources you have highlighted do not meet our inclusion criteria (Turnell and Essex (2006) was excluded on evidence type – book; links on Signs of Safety do not relate to empirical evidence).
The Association for Family Therapy and Systemic Practice in the UK	Short	29	3 to 14	AFT welcomes the specific recommendations to do with supervision and support for staff in this guideline.	Thank you for your comment, and for your support for the guideline.
The Association for Family Therapy and Systemic Practice in the UK	Short	29	4 to 7	It is just as important for staff who are not co-located to maintain their professional skills and competencies	Thank you for your comment. We have removed reference to co-location following consultation feedback.
Association of Independent LSCB chairs (AILC)	Short	General		We welcome the opportunity to comment on the draft guidelines which will have an important impact on the effective safeguarding of children and young people. AILC is willing to contribute to further work on developing these guidelines	Thank you for your comment. The guideline is intended to add further detail,

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				on a partnership basis. We believe it is critical that NICE engages actively with those responsible for delivering safeguarding arrangements at a local level. We are unclear how these guidelines will work alongside the guidance on assessment and preventing abuse and neglect contained in Working Together issued by the Department for Education. We are concerned that the size and complexity of the guidelines will make them an unwieldy and potentially confusing guide to practice. We believe a much shorter and simpler publication that encourages professional curiosity and responsibility would be more useful. We have a number of points about the guidelines which we believe in their current form could be confusing and unhelpful in ensuring effective, consistent and appropriate practice in recognising abuse and neglect and ensuring that families, children and young people are able to access the support and assistance they deserve. Overall the guidelines follow a treatment or intervention model, and inadequately recognise that successful work with children and their families must be developed on a relationship basis. The default position is a medical model, and the guidelines pay insufficient attention to the need to build sustained and respectful relationships with children and families. The guidelines make no reference to the developing practice models and approaches for working with families, such as signs of safety or restorative approaches, which have been adopted in many places to underpin multi-agency work. The recommendations for therapeutic interventions (1.6) are commendable but unlikely to be resourced or available. The guidelines make little reference to the critical role of schools in identifying, assessing and supporting children at risk of abuse and neglect. There is inadequate reference to the specific needs of children with multiple needs, special educational needs or disabilities, and the particular risks of abuse and neglect to which they may be exposed. It is not clear whether this advice would be available or used by all practitioner in the children's workforce or is intended for health professionals. There is a danger that is sets out expectations which differ from those to be followed by social works, school staff and early years providers which is unhelpful. We would strongly argue for a common approach that is compatible across all those working with children, young people and families Child development indicators of neglect may also include obesity as well as faltering growth. This section could usefully refer to exploitation and trafficking for drug and alcohol abuse, and to the emerging issue of county lines. This is a critically important principle that should be more strongly emphasised. Recognition of the interaction between siblings within a family dynamic is also important and is not emphasised in the guidelines. The section on assessment underplays the complex nature of family relationships and that parents and careers can be the source of risks as well as protective factors. In some cases parents and careers will be the perpetrators of abuse or neglect. The emphasis on early help is positive but the guidelines' proposed levels of intervention and support that are quite unrealistic and unresourced in the current delivery of children's services. A programme of home visits lasting at least 6 months is likely to be unsustainable however desirable. Reference to joint visits and work on a multi-agency basis should be added here. Although there is a great deal of good practice and sound advice contained in the guidelines we do not believe that they provide a workable, practical set of guidelines for multi-agency work with children and families at risk of abuse and neglect. There is insufficient emphasis on the multi-agency, multi-professional approaches needed to successfully safeguard children, or on the continuing, relationship based work that is required to support families rather than a intervention and treatment model. We have not had the opportunity to review all parts of the guidance, which as we say, we believe is too long and unwieldy as a guide to day to day practice, but we have highlighted a number of key points above for your attention.	based on a systematic review of research evidence, to guidance in Working Together 2015. In response to stakeholder feedback, we have clarified this further in the introduction, and also cross-referenced relevant content in Working Together 2015 throughout the guideline. We are developing a number of products to help practitioners use the guidance. This includes a concise 'quick guide' for practitioners. NICE has also developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance. The committee were cognisant of the importance of a social model of care. In developing the guideline we developed a series of review questions relating to 'aspects of professional practice'. These questions sought to explore professional practices which did not fit easily within the concept of 'an intervention'. This evidence contributed to a number of recommendations. With regard to relationship-based practice, recommendations 1.1.10 and 1.1.11 emphasise the importance of building relationships with families as a general principle. It is intended that these recommendations would be applied alongside any recommended intervention. Recommendations 1.5.1, 1.5.2, 1.5.3, 1.7.1, 1.7.2 and 1.7.3 also emphasise the importance of engaging in dialogue with children, young people and families regarding any support and interventions, and offering any interventions based on clear assessment. With regarding to resourcing and availability of therapeutic interventions, the committee considered carefully the cost-effectiveness evidence where available, including economic modelling in relation to recommendation 1.7.10 (SafeCare) and recommendation 1.7.17 (trauma-focused CBT), and cost-effectiveness evidence in relation to recommendation 1.7.19 (group psychotherapy). Where cost-effectiveness evidence or economic modelling was not available, the committee made 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence. 'Consider' means that practitioners should think about providing the intervention, rather than that they must offer it. The committee also considered the availability of therapeutic interventions. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic
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		General			interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Given all these considerations, the recommendations were felt by the GC to be aspirational but achievable. With regard to models such as Signs of Safety – we did an extensive evidence search and screened a wide range of evidence. We aimed to use the highest quality evidence to inform practice. This meant that evidence on some emerging models, including Signs of Safety, was of insufficient quality for inclusion. The audience for the guideline is intended to include health, social care, and education staff (as well as other key groups as detailed in the introduction). This has now been made clearer in the introduction and at the beginning of all relevant sections. Additional information on audiences has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, With regard to the needs of disabled children, or those with special educational needs, we have made recommendations for this group specifically in relation to tailoring communication (recommendation 1.1.2), highlighting their increased vulnerability to abuse and neglect (recommendation 1.2.3), taking these issues in to account in relation to recognition (see Section 1.3) and seeking specialist input in to assessment (recommendation 1.4.6). With regard to obesity as an indicator of neglect – this evidence base was considered as part of the development of NICE's guideline on child maltreatment. The guideline committee for this guideline thought the evidence was insufficiently strong to support a recommendation. With regard to trafficking for drug and alcohol abuse, recommendation 1.3.46 aims to remind pracittioners that trafficking may be for reasons other than sexual exploitation. With regard to sibling dynamics, we have added specific reference to siblings in recommendation 1.4.4 on assessment. With regard to early help home visiting, the guideline committee considered carefully the resource impact of the recommendations on home visiting. This is
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					a 'consider' rather than an 'offer' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it. The view of the committee was also that many local areas do offer these interventions. The recommendation that these should last for 6 months is also based on the available evidence. In relation to multi-agency approaches, the view of the committee was that these are well described within Working Together 2015, and did not need to be duplicated here.
Association for Improvements in the Maternity Services	Short	1	intro	The first para refers to assessment for suspected abuse and neglect and provision of early help. Since early "help" is supposedly provided only after this process, the family is already suspicious, fearful and antagonised. The pejorative labelling and investigative process is in itself damaging, and even (in maternal deaths) shown to be related to suicide.	Thank you for your comment. We recognise that the process of assessment, including early help assessment, can be stressful for families. Section 1 of the guideline provides recommendations relating to how practitioners can be build constructive working relationships with families. Recommendations 1.5.1, 1.5.2 and 1.5.3 also emphasise the importance of engaging in dialogue with children, young people and families regarding any support and interventions, and offering any interventions based on clear assessment.
Association for Improvements in the Maternity Services	Short	4	14-22	Communicating with children. This says nothing about pre- verbal babies and toddlers, whose body language often speaks volumes (eg in transfers between separated parents). We have observed this in the presence of social workers, who ignored it and made and wrote no comments.	Thank you for your comment. The section on alerting features (see Section 1.3) is intended to give a series of non-verbal indicators of abuse and neglect.
Association for Improvements in the Maternity Services	Short	9	9	Mental health problems increase risk of abuse,neglect. Mental health problems are common after childbirth, and in every case we have seen where a referral to social services was made, even more harm was done and illness was exacerbated (maternal deaths from suicide are associated with social services intervention). We know from our help line that women are still concealing postnatal mental illness for fear of referral to social workers, whose ignorance and authoritarian behaviour, which we have witnessed, can be insensitive.	Thank you for your comment. We acknowledge that parents with mental health problems can be afraid of seeking support. Recommendation 1.1.10 encourages practitioners to work in a non-blaming way, and to recognise and address parents' worries.
Association for Improvements in the Maternity Services	Short		18	Risk increased by parent who suffered child abuse. Those who have never reported abuse are unknown. We know from our confidential helpline of many such parents, who, unknown to the authorities, made sure they would be safe for their own children by taking parenting courses and taking extra care. A blanket assumption that previously abused parents can be risky can do great harm, so parents keep silent about their own trauma	Thank you for your comment. The recommendation is not intended to imply that all parents who have been abused themselves will abuse or neglect their own children. However, the evidence suggests that there is an increased risk, which fits with what is known about intergenerational abuse and neglect.
Association for Improvements in the Maternity Services	Short	11	15	Bullying or being bullied as a sign of neglect or abuse. We receive a number of reports from parents about their children being bullied at school and official school remedies either not being applied or being ineffective. It is often a reason for school refusal or truanting by the child, which can also cause damaging reactions from authorities. It can be in the interests of teachers or schools to point the finger at parents instead. It seems an unlikely sign of abuse when other reasons are more common . We would prefer this to be omitted.	Thank you for your comment. The evidence suggested that there is a statistically significant association between children who are bullied and those who are abused or neglected.
Association for Improvements in the Maternity Services	Short	15	16	Research shows that accidental injuries are more likely in poorer families and in rented accommodation. The unsuitability of the rented premises can often be a factor. Quality of housing and the street environment should be considered	Thank you for your comment. We have added a recommendation regarding environmental vulnerability factors, including poverty and poor housing (recommendation 1.2.2).
Association for Improvements in the Maternity Services	Short	15	24	We often hear of parents blamed for not taking up appointments they had never been notified of. This happens so often, in so many areas, we suspect either widespread inefficiency, or a deliberate ploy. Please note also that parents have a right to refuse treatment they consider unsatisfactory or risky for their particular child.	Thank you for your comment. We recognise that there may be other reasons why parents repeatedly do not bring their children to appointments. However, the evidence reviewed for the NICE guideline on child maltreatment from which this is

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					taken suggested that this behaviour can be an indicator of abuse and neglect. The wording 'consider' implies that professionals should gather more information before acting further.
Association for Improvements in the Maternity Services	Short	15-16	27	Please note immunisation and screening programmes are voluntary (as is emphasised by the NHS Screening Committee) and that orthodox advice is not always right – eg the thousands of babies who suffered cot death as a result of advice to put them to sleep face down. Parents have a right to choose for their children; we are not raising clones. Parents who occasionally question authority, and encourage children to do likewise are useful in the preservation of democracy	Thank you for your comment. We acknowledge that immunisation is voluntary. However, the evidence reviewed for the NICE guideline on child maltreatment from which this is taken suggested that this behaviour can be an indicator of abuse and neglect. The wording 'consider' implies that professionals should gather more information before acting further.
Association for Improvements in the Maternity Services	Short	19-20	20 et sec	Home Visiting Programme. We know only of the evidence of benefit from Family Nurse Partnership programmes in the UK but receive many adverse reports of other home "visiting" and agree that this should be done only by those in a researched programme with longer term follow up.	Thank you for your comment. This guideline is intended to support the provision of evidence-based home visiting programmes. We have also made a research recommendation regarding the provision fo home visiting to families where abuse and neglect has occurred.
Association for Improvements in the Maternity Services	Short	22350	18	Believing children. We have become increasingly aware of a number of cases where older children, having seen parents disempowered by social workers, can use allegations or threaten to do so, in order to get their own way, or to gain presents. This has been a neglected aspect of research.	Thank you for your comment. Reference to being believed has been removed from this recommendation (now 1.5.4).
Association for Improvements in the Maternity Services		23	13	We greatly welcome at least the suggestion of choice here, though we suspect with the deficiencies of CAMHS services parents report from many areas, this will seldom be available in practice.	Thank you for your comment. The guideline committee considered carefully the resource implications of the recommendations. They acknowledged the financial constraints in the sector, but thought it was important to continue to recommend good practice as identified by the research evidence.
Association for Improvements in the Maternity Services	Short	25	16	There is a group not mentioned here, which is parents being abused by children (eg older children with serious mental health problems, ADHD, etc) Social Workers are most unhelpful in these circumstances, even when parents or carers are frail or disabled.	Thank you for your comment. Parents being abused by children are outwith the scope of this guideline. Abuse of parents by children is covered the NICE guideline on domestic violence and abuse.
Association for Improvements in the Maternity Services	Short	6	29-30	Explaining what information has been shared. Please add:" and share also information when parents have been cleared." We have seen many cases where parents have been proved innocent of abuse or neglect (eg child's condition is now diagnosed by paediatrician) but damaging allegations about them remain on files of many agencies, which can re-surface and do further avoidable harm.	Thank you for your comment. We have amended recommendation 1.1.11 to include the bullet point 'be clear about the issues and concerns that have led to your involvement, and inform parents and carers if those concerns are resolved'.
Association for Improvements in the Maternity Services	Short	9	6-9	Missing from this list is the major and most common risk factor,: poverty, about which there is ample literature. *(Bywaters Paul et all 2016 The relationship between Poverty, Child Abuse and Neglect, an Evidence Review. The Rowntree Trust)*	Thank you for your comment. We have added a recommendation relating to poverty (recommendation 1.2.2).
Association for Improvements in the Maternity Services	Full	12	1.1.12	Working with parents: Add: Allow parents to record interviews to encourage trust, especially if they say they have experienced previous dishonest reports. Why is it recommended on the previous page that a written record is produced and agreed only for children, and not for parents? (P.11. 1.1.6)	Thank you for your comment. We have added the following bullet point to recommendation 1.1.11: 'agree records of any conversations, and share relevant documents and plans'.
Association for Improvements in the Maternity Services	Full	18	1.2.24	Other families in poverty may secretly use food banks, having overcome their shame and humiliation at needing to do so.. and therefore may appear to manage better.	Thank you for your comment. We acknowledge that it may not always be apparent when families are living in poverty.
Association for Improvements in the Maternity Services	Full	20	1.2.30	Children's behaviour to parents. The behaviours listed here are often typical in teenagers. No age is specified in the Guideline.	Thank you for your comment. We have defined 'child' in the guideline as being from 1 to 13 years, and 'young person' as 13 to 17 years. This recommendation therefore refers to younger children.
Association for Improvements in the Maternity Services	Full	20	1.2.31	Exposure to domestic abuse. Please add "The abuser is the perpetrator of the violence, and the victim of it is not abusing the children. Despite this, it is the victim , who is often blamed by social workers	Thank you for your comment. Exposure to domestic abuse has been removed from this recommendation (now 1.3.31) as this is constitutive of abuse, rather than an

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					indicator of abuse or neglect.
Association for Improvements in the Maternity Services	Full		1.2.33	Emotional unavailability to an infant. This is usually caused by post-natal mental illness, for which mothers should not be judged or blamed but helped.	Thank you for your comment. We recognise that there may be a rnage of reasons why parents may be emotionally unresponsive. The wording 'consider' implies that professionals should gather more information before acting further.
Association for Improvements in the Maternity Services	Full	23	1.3	Assessments, including for early help. There is no understanding here that assessment in itself can be damaging, as our many case files show. One of the long term effects is that families restrict any information they give to any official organization in future, and feel they can trust no-one, even their own GP or midwife. Moreover there is ample evidence of damaging outcomes from such interventions in large randomised trials in the USA comparing current style social work with differential (or alternative) response (Kempe Center: Differential Response: one size does not fit all http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/Pages/DiffResp.aspx Randomised studies in Minnesota and Ohio have shown that children are at least as safe, if not safer under DR, that fewer children are removed, long term costs are no higher, families are happier and social workers more popular (1) (2) |In view of the rising numbers of families involved in the UK, we question the exclusion of differential response literature, which includes the only large randomised studies of social work with long follow up Perhaps there is too much suspicion of a model built on family empowerment and building on family strengths, rather than dis-empowerment and control. 1) Loman L A et al. Ohio Alternative Response Evaluation:: Final Report Institute of Allied Research, St Louis, Missouri USA 2) Institute of Applied Research (2006) Extended Follow-up study of Minnesota's Family Assessment Response Final Report. Institute of Applied research, St . Louis, Missouri USA	Thank you for your comment. The guideline committee were cognisant of the stress that can be caused to families by the assessment process. The guideline committee considered evidence on differential response (Winokur et al. 2014) but it was considered insufficiently strong to base a recommendation on. Thank you also for suggesting the reports on the Ohio Alternative Response programme. We screened a number of studies relating to this programme, but they did not meet our inclusion criteria for the question on assessment as they did not relate to a specific assessment tool.
Association for Improvements in the Maternity Services	Full	General	general	We have a collection of cases where malicious and false reports of neglect or abuse were made to social services either in response to complaints about care or teaching, or to pre-empt anticipated valid complaints. The only reports we have seen of false malicious complaints have concerned marital disputes over custody where one parther accuses the other of neglect or child abuse. We think this should be added as a subject for research	Thank you for your comment. We can only make research recommendations where we have specifically searched for literature and therefore know that there is a gap in available evidence. We did not search for evidence in relation to practice for dealing with malicious or false reports, so have been unable to make a research recommendation in this area.
	Short	9		*Parental risk factors for abuse and neglect* – this gives a list of risk factors but with no weighting re: how much the risk is increased. I think this is extremely poor guidance and leads to appalling social work practice. For example where mental health problems are simply ticked as an increase in risk factors with no understanding of whether this is a 5% increase in risk or a 90% increase in risk. Neither is there any subtlety re: what the protective factors might be. This kind of approach is used in care proceedings to justify removal of children and it's inexcusable. I also think it's unacceptable in terms of equality issues for those people with	Thank you for your comment. We have added introductory text to this section (section 1.2), clarifying that the presence of these factors does not mean abuse or neglect will occur, and professional judgement should be used to assess the significance of these factors.
	Short	14		Consider emotional abuse if there is concern that parent– or carer–child interactions may be harmful. Examples include: Exposure to frightening or traumatic experiences, including domestic abuse. There is horrific social work practice in relation to victims of domestic abuse which holds victims responsible for emotionally abusing their child by allowing themselves to be beaten up or otherwise abused in front of their child. The kind of guidance written above promotes such appalling practice and should be removed or substantially reworded.	Thank you for your comment. Exposure to domestic abuse has been removed from this recommendation (now 1.3.31).
	Short	14		*Re: Consider neglect or physical abuse if a child's behaviour towards their 6 parent or carer shows any of the following, particularly if they are not observed in the child's other interactions:* There is no reference to age related differences in behaviour – in fact the list reads as a fairly normal account of a parent/teenager relationship/	Thank you for your comment. We have defined 'child' in the guideline as being from 1 to 13 years, and 'young person' as 13 to 17 years. This recommendation therefore refers to younger children.
	Short	General		I think you need to go back to the drawing board with this guidance – it's deeply flawed and unhelpful	Thank you for your comment. We have received a substantial amount of stakeholder feedback which we are using to refine and reshape the guideline.
The Association of Teachers and Lecturers	Short	4	14-16	ATL members, responding via survey, agreed with the child-centred approach, including the involvement of children and young people in decision-making, for all or some of their pupils, with 76.9% saying that it fully or sometimes fit with the practice within their education settings. However, it's worth noting that some respondents were unsure whether this	Thank you for your comment. This recommendation aims to make this practice more widespread.

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				approach reflected practice within their settings, indicating that not all frontline staff are aware of this as a priority in their settings.	
The Association of Teachers and Lecturers	Short	4	14-16	Question 3: Further training around the child-centred approach, across all staff, would help users heighten their awareness of this approach, the rationale behind it and how it works most effectively in practice.	Thank you for your comment. We would encourage organisations to undertake training as part of implementing the guideline.
The Association of Teachers and Lecturers	Short	4 5	17-22 1-2	ATL recognises the diverse needs of the children and young people with whom our members work, consistently calling for education settings having the range of resources and expertise to meet those needs. Members' experiences however, often attest to the inconsistent provision of these resources and the variability of range in methodology and practice across settings, meaning that these expectations may be difficult for some professionals to fulfil in their settings, a situation which is likely to worsen under the current proposed funding plans, which will reduce budgets in settings which have struggled to ensure staff access to resources and training for years.	Thank you for your comment. The guideline committee gave careful consideration to the resource impact of their recommendations and were aware of the widespread resource constraints that exist. However, the committee thought it was important to recommend and highlight best practice, based on the research evidence.
The Association of Teachers and Lecturers	Short	5	15-16	Whilst ATL members agreed with the needs for privacy for children and young people around the sensitive issues raised within the guideline, reflecting that this is essential and fits with settings' policies, some were concerned that there were few or no appropriate spaces within their settings for this. This exposes the demands on space within many settings, likely to worsen as pupil numbers rise, which they are forecast to do over the next five years.	Thank you for your comment. Again, the committee were mindful that resources may be required to ensure that children and young people have private spaces in which to talk, but were keen to highlight good practice in this area.
The Association of Teachers and Lecturers	Short	5	24-27	The recommendation that professionals produce a written record of conversations with children and young people if relating to issues around abuse or neglect, checking agreement, using their actual words, if possible, fits with the settings of over two-thirds (69.2%) of ATL survey respondents, and is recognised as best practice. However, concerns about the workload impact of this, within a profession in the middle of a workload crisis which is driving increasing numbers to leave the profession early (affecting all groups, including middle leaders), will means that in practice, this recommendation will prove very challenging to those working in education. Compounding that, education is facing a funding crisis which is leading to support staff redundancies, a group key to supporting many of our most vulnerable children and young people in education.	Thank you for your comment. This recommendation has been amended to refer to producing a record in writing, or another suitable format. This could include a tape recording, which may present less of an impact on workload.
The Association of Teachers and Lecturers	Short	9	6-11	ATL's members largely agreed with the risk factors listed for parents, carers, siblings or other adults in a child or young person's household, to lead to the consideration of child abuse and neglect, although there was a significant lack of certainty amongst respondents, particularly relating to mental health problems (38.5%) and lack of support from family and friends (53.9%). This reflected members' feeling that individual circumstances should always be considered, that these guidelines should be rooted in a deeper understanding, and training, for practitioners.	Thank you for your comment. The introduction to section 1.2 highlights the importance of practitioners using their judgement to think about how particular vulnerability factors affect the individual circumstances of a child or family.
The Association of Teachers and Lecturers	Short	10	1-2	We welcome the statement that current abuse or neglect should be considered if there is a **marked change** in behaviour or emotional state or repeated, extreme or sustained emotion responses. Bearing in mind that eye-catching list, in Box 12 (6th 'line'), and the importance of change as a cause for concern, these two points needed to be emphasised more clearly. Perhaps some given examples would be useful to practitioners.	Thank you for your comment. These recommendations have been restructured to make the examples easier to connect to the main recommendation.
The Association of Teachers and Lecturers	Short	10	3-5	Following on from comment 7, we welcome the warning against practitioners' assuming that changed behaviour or emotion state or extreme emotional responses relates to a known stressful situation. This should be included within the emphasis given to the previous content in lines 1 and 2.	Thank you for your comment. We have added text in to the introduction to the section on alerting features to emphasise that practitioners should continue to consider abuse and neglect as possible explanations, even if there appears to be an explanation for changed behaviours or emotional states.
The Association of Teachers and Lecturers	Short	10	6	The examples of behaviour and emotional states given in relation to the need to consider current abuse and neglect are comprehensive and the majority of our survey respondents agreed with most of them. However, our practitioners' certainty (they marked 'Unsure' rather than 'Agree' or 'Don't agree') levels dipped in relation to examples such as 'Lack of ability to understand and recognise emotions' (46%), 'excessive clinginess'(61.5%), 'demonstrating excessively 'good' behaviour to prevent parental or carer disapproval' (53.9%), 'failing to seek or accept appropriate comfort..' (38.5%). Some acknowledgement that these examples could relate to undiagnosed special educational or mental health need, would be useful, particularly in education, where lack of time and training can impact on practitioners' level of knowledge and understanding around these.	Thank you for your comment. These recommendations are based on empirical research evidence and the deliberations of the guideline committee who developed NICE's guideline on When to suspect child maltreatment.
The Association of Teachers	Short	12	25-27	With 3.9 million children (28% of children) living in poverty in the UK in 2014-15, we welcome the reference to the	Thank you for your comment. We have

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and Lecturers		13	1-2	impact of poverty and the warning of the difficulty in distinguishing between neglect and material poverty. However, the section of the statement on p.13, lines 1-2, is rather ambiguous and does little to help the practitioner in dealing with that difficulty. It would be useful if the guidance includes links to organisations that can provide support around poverty; should a family's experience of poverty lead to the child suffering impact on their access to food, clothing and shelter, practitioners will need practical advice and support in order to provide the conversations and interventions which can meet the needs of the affected child or young person.	now added reference to poverty as a vulnerability factor for abuse and neglect. NICE guideline would not usually include information about specific organisations.
The Association of Teachers and Lecturers	Short	15	12-15	Bearing in mind the acknowledged difficulty in achieving a balance between an awareness of risk and allowing children freedom to learn by experience, practitioners would find examples around this useful, particularly as it relates to the higher category of 'suspecting' rather than 'considering' neglect.	Thank you for your comment. This recommendation has been amended to 'consider'.
The Association of Teachers and Lecturers	Short	16	19-20	The results of our recent survey showed that less than half (46.2%) felt fully confident to recognise and respond to child abuse and neglect although the same proportion felt confident sometimes to recognise and respond to child abuse and neglect. Comments reflect the need for further training in this area; some felt that the necessary knowledge and understanding was probably within their setting, but that they didn't always know enough to identify issues and to escalate matters appropriately themselves. In another recent survey around member awareness of honour based abuse, FGM and child abuse linked to faith or belief, 31.3% of respondents cited a lack of confidence in their own judgement in reporting around these areas.	Thank you for your comment. We would encourage organisations to deliver training as part of implementing this guideline.
The Association of Teachers and Lecturers	Short	17	8-9	The guideline's advice to practitioners to recognise that choosing an interpreter from the child's community could expose them to the community which has exploited them, is not particularly helpful to practitioners. It would be useful if this section could be expanded to refer to a range of organisations which could provide advice and guidance around such practical and key issues.	Thank you for your comment. Choosing interpreters who are not from within the child's community is best practice based on the empirical evidence. NICE guidelines would not usually refer to speak organisations.
The Association of Teachers and Lecturers	Short	19	14-17	ATL strongly supported the previous Every Child Matters agenda and the Team around the Child approach as part of that. We are also clear that education practitioners must have support from, and work with, other agencies and professionals. However, we hope that the guideline will note that many settings experience difficulties / delays in accessing the specialists they need, due to the huge cuts to local support services and funding issues around support services/agencies for vulnerable children and young people.	Thank you for your comment. The guideline committee carefully considered the resource impact of the recommendations, but thought it was important to continue to highlight evidence-based best practice.
The Association of Teachers and Lecturers	Short	21	23-25	The recommendation around response and support following abuse and neglect, including retaining responsibility for child protection referrals, including follow-up and ensuring appropriate action, is seen as particularly challenging in light of the current lack of access to local external agencies, lack of staff, increasing waiting times and funding issues. As staff shortages in many education settings increase, which current staff and pupil figures and trend suggest they will, this recommendation will become less possible to achieve.	Thank you for your comment. We have removed this recommendation as consultation feedback suggested it did not add anything to what is in Working Together 2015.
The Association of Teachers and Lecturers	Short	28	11-15	We welcome the highlighting of less-recognised forms of abuse, including female genital mutilation (FGM), around which ATL has campaigned, raising awareness amongst those in education. However, not unrelated, education staff can face issues around honour based abuse (of which forced marriage can be part) and child abuse linked to faith or belief, which we believe should be added to the listing of abuse in this section.	Thank you for your comment. We have added reference to honour-based abuse to this recommendation.
The Association of Teachers and Lecturers	Short	28	16-23	In light of the importance of agencies and sectors working together to protect children and young people, we welcome this section around the need to address obstacles to partnership working, including the reference to supporting guidance documentation and working examples. Indeed, the examples could be expanded upon to share further ideas of good practice.	Thank you for your comment. We are glad that these recommendations will support developments in this area.
The Association of Teachers and Lecturers	Short	29	8-14	We agree with the statement that organisations should support staff working with children and families at risk of experiencing abuse, ensuring that they have access to good quality supervision. However, it's clear that for many of our members, this level of support is not provided. Only around half said that they either had, or sometimes had access to the following: case management (46%), reflective practice (38%), emotional support (57%), continuing professional development (53%).	Thank you for your comment. The evidence we reviewed also emphasised that some aspects of supervision are often neglected. We hope this recommendation will address that.
The Association of Teachers and Lecturers	Short	General	General	Following on from comment 16 above, we believe that a document of this comprehensive nature should include further examples of honour based abuse/violence, including breast ironing, and also child abuse linked to faith or belief, to increase the awareness and knowledge of education practitioners around these issues, including the identifying and risk factors. Less than 50% of recent ATL survey respondents said that they'd been given information and/or training which would equip them to identify and report the following; honour based abuse (37.7%), breast ironing (13%), forced marriage (48.2%), child abuse linked to faith or belief (36.3%). This exposes a need which we believe should be reflected in the guideline.	Thank you for your comment. We found little empirical evidence relating to honour-based abuse or faith-based abuse. Recommendation 1.8.3 recommends that local threshold documents should set out local responses to forms of abuse including female genital mutilation, honour-based abuse (including forced marriage). We have also made research recommendations regarding forced marriage and female genital mutilation.

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					The issue of breast ironing was not included in Working Together at the time our scope was developed (we used Working Together as the basis for our definition of abuse and neglect), and so was not included in the scope for the guideline.
The Association of Teachers and Lecturers	Short	General	General	As with the previous comment, it's key that this NICE guidance, as a comprehensive document, more strongly reflects that children and young people with a disability and/or a special educational need (SEND) are at increased risk of experiencing abuse (useful evidence - 'We have the right to be safe' NSPCC report, 2014). To support these children and young people through identification of abuse and/or development and implementation of preventative strategies, practitioners need access to specialists. Training on the specific vulnerabilities of SEND pupils should be available to all with statutory reporting duties and this guideline could provide highly useful signposting to training and key information to raise awareness with practitioners.	Thank you for your comment. Recommendation 1.2.7 highlights that disabled chidlren are at increased vulnerability to abuse and neglect. Recommendation 1.4.6 states that practitioners should have access to specialists when assessing abuse and neglect in disabled children. The NSPCC publication you mention, 'We have the right to be safe', was considered for inclusion in the guideline, but it did not meet the review protocols' criteria for inclusion. Thiis was on the grounds that it was not an empirical research study.
The Association of Teachers and Lecturers	Short	General	General	We welcome the recommendations for research, particularly around recognition of sexual abuse, FGM, honour based violence and forced marriage.	Thank you for your comment.
The Association of Youth Offending Team Managers	Short	General	General	We are concerned about the lack of age-specific context in this consultation document. It appears to be geared towards younger children. Whilst this is important, given that younger children cannot advocate for themselves, it is nonetheless critical to recognise the vulnerabilities of older children as well, and this guidance needs some emphasis on older children as well. Older children should not be invisible, as they have needs and vulnerabilities, as well as sometimes posing risks to themselves and others. There is a tendency to blame older children for what happens to them (e.g. see Rotherham CSE report http://www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham), which risks not recognising them as children under UNCRC 1989. As a result, it can also mean their needs are not identified and addressed, despite their vulnerabilities.	Thank you for your comment. We concur with the importance of ensuring the voices older children and young people are heard. Recommendation 1.1.1 makes reference to taking a child-centred approach. Recommendations 1.1.3, 1.1.4, 1.1.6, 1.1.7, 1.1.8 and 1.1.9 refer to ways of working that would be appropriate to work with older children and young people. Therapeutic interventions for supporting children and young people over 10 and their parents or carers are suggested in 1.7.10, and for carers of children and young people aged 5-17 in 1.7.14. The guideline does make recommendations for further research into certain types of abuse that are more likely to affect older children, such as FGM, and 'honour-based' violence and forced marriage.
The Association of Youth Offending Team Managers	Short	5	1	'Communication needs' should be considered more broadly than expressed here, to ensure all young people are heard. For example, at least 60% of young people who offend have speech, language and communication needs. See https://www.thecommunicationtrust.org.uk/projects/youth-justice/	Thank you for your comment. We agree with your statement that young people's communication needs should be taken into account, and one of the guideline's principle's for working with children and young people is to use a range of methods for communicating, tailoring communication to their needs (1.1.2).
The Association of Youth Offending Team Managers	Short	5	3	Section 1.1.3. needs an additional bullet point to recognise that young people are often so damaged by neglect that they are often unable to share their history of being abused. It can take a prolonged period of time to build up the trust required for such disclosure. This area is covered in Sections 1.2.1/2/3. but needs referencing here	Thank you for your comment. This recommendation covers general conversations, not just disclosures. The committee have therefore focused on behaviours that apply across all types of conversations.
The Association of Youth Offending Team Managers	Short	10	6	Box 1 (examples of behaviour and emotional states) should include self-harming, and self-destructive behaviours such as putting oneself at risk. This is applicable to both boys and girls, but especially girls who are offending.	Thank you for your comment. Recommendation 1.3.16 refers to self-harm.
The Association of Youth Offending Team Managers	Short	15	24	This section needs the addition of parents who fail to facilitate the attendance of a young person. Young people usually have little or no income, and so appointment FTAs can be due to parents/carers not supporting them to attend.	Thank you for your comment. This recommendation has been amended to refer to parents who 'do not bring' their children to appointments.
The Association of Youth	Short	17	20	When carrying out assessments for neglect/abuse it is best practice to actively involve a known, trusted professional	Thank you for your comment. The

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Offending Team Managers				where one is working with the young person. Bringing such a trusted person with an existing professional relationship into the assessment will facilitate openness and communication.	recommendations made by the Guideline Committee were based on the evidence reviewed.
The Association of Youth Offending Team Managers	Short	17	24	Exceptions to significant people involved in assessments should not be restricted purely to adults involved in a criminal investigation. Older siblings might be involved as informal carers and in abuse, and they may be under 18 years.	Thank you for your comment. Recommendation 1.4.4 has been reworded to make clear that exclusion of individuals from the assessment process could apply to a range of people, including siblings.
The Association of Youth Offending Team Managers	Short	19	27	Home visit programmes as described assume that the young person is not currently living independently at age 16 or 17, which is sometimes the case in abusive families.	Thank you for your comment. We recognise the importance of this group. However, the evidence we reviewed relating to home visiting programmes for parents and children still living at home with them. We did not find evidence relating to home visiting interventions for 16 and 17 year olds. We were therefore unable to make recommendations about these intervention.
The Association of Youth Offending Team Managers	Short	39	1	We support the recommendations for further research into the areas specified in this section.	Thank you for your comment.
The Association of Youth Offending Team Managers	Short	42	19	We consider interventions with male parents/carers as very important, and any research which focuses on how to do this effectively would be most welcome. There is a need for programmes for young men to explore masculinity.	Thank you for your comment.
The Association of Youth Offending Team Managers	Short	General	General	AYM sees these NICE guidelines as positive and well-researched. We support them with the above general point about needing to be more age-specific for older children, plus our other specific comments outlined.	Thank you for your comment. We have made recommendations applicable to children and young people across the age spectrum. However, we found less evidence on effective interventions for older children and young people. We have made a research recommendation with the aim of addressing this.
British Association for Counselling and Psychotherapy (BACP)	**Short**	23	13 - 15	BACP fully supports giving children, young people and their families a choice of proposed interventions. BACP believes that it is beneficial for the therapeutic relationship to offer clients full and informed choice when accessing psychological therapies. We recommend that people are offered an informed choice of the full range of NICE recommended psychological therapies, as well as a choice of therapist, appointment times and location.	Thank you for your comment. We hope that this guideline will encourage a choice of therapeutic interventions.
British Association for Counselling and Psychotherapy (BACP)	**Short**	general	general	BACP believes that there is an absence of specialised services for children referenced in the guideline. Services such as those provided through Barnardo's, who work with children or young people around sexual abuse with play based directive and non-directive work.	Thank you for your comment. We hope that this guideline will encourage commissioning and provision of specialist therapeutic interventions.
British Association for Counselling and Psychotherapy (BACP)	**Short**	26	26 - 27	BACP believes that there are several key requirements for the provision of counselling and therapy for children and young people who have been abused, these are: i. Living in a safe and secure environment, where their physical and emotional needs are being met. ii. Supportive carers can have a significant impact on the outcomes of therapeutic work. iii. Consideration given to how therapy may affect ongoing legal proceedings. iv. As previously mentioned, an informed choice of what type of therapy they receive. v. Some children may not wish to attend counselling or therapy sessions, and careful consideration should be given to the extent to which they are pressured to do so. vi. Consideration should be given to other events taking place in the child's life at the point of referral, so that the timing of the intervention is compatible with other priorities such as relationships, education and home life. Source: Pattison, Sue, Maggie Robson and Ann Beynon (2015) *The Handbook of Counselling Children and Young People*. Sage	Thank you for your comment. Recommendations 1.7.2 and 1.7.3 refer to giving choice of interventions, and selecting the right intervention based on detailed assessment.
British Association for Counselling and Psychotherapy (BACP)	**Short**	general	general	BACP is supportive of the draft guideline that NICE have consulted upon, in particular we are supportive of the principles of choice offered to clients and the broad range of interventions recommended.	Thank you for your comment. We hope that this guideline will encourage choice of therapeutic interventions
Barnardo's	Short	general	general	Barnardo's welcomes the opportunity to respond to the substantial new guidance that NICE has developed on child abuse and neglect. Our comments below are made with particular reference to child sexual abuse and exploitation.	Thank you for your comment.
Barnardo's	Short	10 & 11	general	This section includes Behaviour and emotional states and responses. In relation to child sexual exploitation, the child	Thank you for your comment. Reference to

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				starting to receive unexplained expensive gifts, new phones, money or other items should be included as 'contextual' as these could indicate the child is being groomed or exploited.	exchange in return for something the child or young person wants is included within the definition of child sexual exploitation.
Barnardo's	Short	9	7	The list of risk factors among parents and others in the household should also include any concerns regarding sexual violence, including sexual exploitation and grooming (Smeaton, E (2013) Running from hate to what you think is love: The relationship between running away and child sexual exploitation. Barnardo's and Paradigm Research). Sexual violence may be as a result of domestic violence, but may also be inflicted outside of the home, such as in sexually exploitative situations. It is recommended that this read 'There is a history of domestic abuse and/ or sexual violence, including exploitation'.	Thank you for your comment. We have added reference to sexual violence and exploitation to recommendation 1.2.3.
Barnardo's	Short	23	4	The term 'safe accommodation' should be more clearly defined, highlighting – or providing a hyperlink to - the strategies that need to be put in place when accommodation is provided to trafficked children. For example, see here.	Thank you for your comment. We have removed this recommendation as it did not add significantly to the supplementary guidance in Working Together 2015.
Barnardo's	Short	26	29	This line refers to group therapy and then has boys and girls in brackets. These brackets appear to suggest that group work takes places with boys and girls in the same group which may not be suitable.	Thank you for your comment. We have amended this wording to 'boys or girls' (see recommendation 1.7.17 and 1.7.18).
Barnardo's	Short	27	16 23 25	This recommendation highlights a particular therapeutic intervention that follows a set number of sessions. Barnardo's has been working with victims of child sexual abuse and exploitation for over twenty years and has found that offering a time-limited programme does not suit all children and young people. For some young people the level of intervention required will far exceed the 20 or 30 sessions cited in the guidance. We fully support that sessions should be on an individual basis and also with family and carers but would recommend that this section be amended to stress that some children will need more than a limited number of sessions.	Thank you for your comment. The number of sessions stated here are based on the research evidence and consideration of resource impact. However, the recommendation does not preclude more sessions being offered if a professional considers this to be required.
Barnardo's	Short	27	8 19	These sections recommend work with 8 – 17 year olds and 6 – 14 year olds but nothing below this age range. Consideration should be given to providing guidance for children under 6 years of age.	Thank you for your comment. These recommendations (now 1.7.17 to 1.7.19) are three possible options for children who have been sexually abused. Recommendation 1.7.17 on CBT does not have a lower age limit, and could potentially be used with children under 6.
Barnardo's	Short	27	19	Whilst the guidance is not gender specific, and refers to boys and girls throughout, this section is aimed at girls only. If this section needs to be for girls only, this should be clarified and reasons given. However, it would be recommended that this session be applicable to boys and girls. In some cases it is recognised that a specific programme may be more suitable for one sex. If this is the case this should be noted and explained.	Thank you for your comment. We have added explanatory text at the beginning of the section to explain why some recommendations are targeted at particular populations (based on the research evidence).
Barnardo's	Short	28	12	Other less well-recognised forms of abuse should include breast ironing and other honour-based violence.	Thank you for your comment. We found little empirical evidence relating to honour-based abuse or faith-based abuse. Recommendation 1.8.3 recommends that local threshold documents should set out local responses to forms of abuse including female genital mutilation, honour-based abuse (including forced marriage). We have also made research recommendations regarding forced marriage and female genital mutilation. The issue of breast ironing was not included in Working Together at the time our scope was developed (we used Working Together as the basis for our definition of abuse and neglect), and so was not included in the scope for the guideline.
Barnardo's	Short	39	1	Recognition of sexual abuse Barnardo's worked with nearly 2500 children and young people at risk of, or victims of, sexual abuse and exploitation in	Thank you for your comment and offer of support.

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				2015/ 2016. We know from our experience that it can take a lot of time and patience before a victim of sexual abuse and exploitation is willing to disclose. We are also aware of the concerns among practitioners of their notes from confidential sessions with service users being potentially used in court. As this is a subject that Barnardo's could assist with, we are happy to offer any assistance if this research was progressed.	
Barnardo's	Short	39	2	Recognition of risk and prevention of female genital mutilation Barnardo's, along with the Local Government Association, run the FGM Centre of Expertise. The Centre employs specialist social workers to provide support to local authorities and work with communities to raise awareness about the problem. The Centre has also developed a FGM Risk Assessment Matrix for social workers, which will be available later this year. Given the link with the Centre, Barnardo's would be very interested in providing assistance with any research on the issue of FGM.	Thank you for your comment. We searched for evidence in relation to tools and approaches to support recognition of FGM but did not find any that matched our criteria. It is encouraging to know that a tool will be available soon.
BASHH	full	general	general	Wedo not have any additional comments as document is very comprehensive and well written and highlights that overall the UK evidence base on which to drawn on the recommendations is lacking. The guideline links in and makes reference to other NICE guidelines which BASHH / RCP have contributed to in the past such as child maltreatment and harmful sexual behaviour among children and young people. This document recognises increased training is likely to be challenging for many organisations because of cuts in resources and therefore putting guideline into practice, which highlights the impact LA sexual health funding will have on standards of service provision and maintaining good quality patient care.	Thank you for your comments. The guideline committee considered carefully the resource impact of the recommendations, and considered that it was still important to recommend best practice as identified by the research evidence. The guideline highlights some of the particular challenges/priorities for implementation.
BASHH	full	1.7	Planning and delivering services	This raise the important issue of supervision and support for staff working with children and YP at risk of or experiencing abuse and that they should have access to good quality supervision, which BASHH are supportive of:: - case management - reflective practice - Emotional support - Continual professional development	Thank you for your comment. We hope the guideline will encourage good quality supervision, which is referred to in recommendation 1.8.5.
British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN)	Short	General	General	Q1. **Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.** BASPCAN welcomes these evidence-based recommendations which could have a significant positive impact on protecting children and young people from abuse and neglect. However, as professional membership organisation dedicated to preventing child abuse and neglect, we are concerned that the ability of organisations and practitioners to implement the guidance will be compromised by current funding constraints, real cuts in services and by the absence of any ring-fenced funding. The guidance, while representing best practice, is aspirational and not based on a realistic assessment of current capacity. Having aspirations for children is admirable but we fear that within the current financial envelope the guidance risks setting up services and individuals to fail. There is a risk that the guidance could be used as a measure to hold providers accountable when there is an assessed need for specialist long term interventions, which are not available in all parts of the country. It is a continuing challenge to provide all practitioners in primary care with access to the necessary training and development to enable them to recognise and respond to child sexual abuse, child trafficking and CSE, while maintaining services. Commissioning evidence-based specialist services for those children experiencing severe neglect and trauma post-abuse will be particularly challenging. The availability of these interventions is currently patchy at best and demand outstrips supply. In addition insufficient numbers of practitioners and clinicians are trained in their delivery. Services for parents with drug and alcohol problems, including those with a dual diagnosis, and those with chronic mental health difficulties are also being cut due to funding problems and are urgently needed to prevent child abuse. In our experience many practitioners have limited knowledge of the range of effective interventions available and selecting the most appropriate intervention is therefore challenging. The guidance talks about co-location and integrative working. These are still very much in their infancy and it seems that assumptions have been made about the current state of services and working practices.	Thank you for your comment. The guideline committee acknowledge the financial contrainsts in many parts of the sector, and considered carefully the resource impact of the recommendations, including making use of economic evidence and economic modelling data, and the practice experience of committee members regarding currently available provision. Although it was acknowledged that many of the recommendations may have resource implications, the committee thought it was important to make recommendations as a way of highlighting interventions that have been shown to be effective, and promoting good practice.. The guideline itself also highlights some of the particular challenges/priorities for implementation. The majority of interventions recommendations are worded as 'consider' recommendations, meaning that practitioners should think about providing the intervention, rather than that they must offer it. In response to your particular comments:

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					- With regard to training our understanding is that in many sectors some level of safeguarding training is already mandatory. Our recommendations are therefore intended to inform the existing training. - With regard to evidence-based specialist services post-abuse and for parents with drug and alcohol problems the committee considered the resource impact carefully. The majority of recommendations are phrased as 'consider' meaning that practitioners should think about providing the intervention, rather than that they must offer it. The committee agreed that practitioners were likely to have limited knowledge of the range of interventions available – the guideline aims to support them to do this. The recommendation in relation to co-location has been removed following consultation feedback.
British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN)	Short	General	General	Q2: **Would implementation of any of the draft recommendations have significant cost implications?** If all the recommendations are to be met it will have significant cost implications both in financial terms and in terms of staff capacity. The guidance recommends (1.4.1) considering a programme of home visits, lasting at least 6 months, for parents or carers at risk of abusing or neglecting their children. This includes parents or carers with previously confirmed instances of abuse and neglect. The evidence was taken from the reviews of effectiveness of early help interventions. Although the economic analysis was inconclusive, the view was that home visiting is a commonly provided model of care and therefore would not require significant additional investment. However, many of the current home visiting programmes are managed on a universal: universal plus or targeted basis and do not offer the intensive programme of home visiting as recommended. This recommendation has significant cost implications based on the gap between current service provided and those recommended . Additional numbers of qualified health staff will be required to fulfil this recommendation in both midwifery, school nursing and health visiting. The guidance appears to assume (1.7.1) that parenting programmes for parents at risk of abusing or neglecting their children are widely available. In our experience these services are patchy and would require additional funding. Addressing the shortfall in the availability of evidence-based therapeutic interventions for children and parents will have significant cost implications. The costs of providing specialist targeted therapeutic interventions are a concern. A number of programmes that have been rigorously evaluated can only be delivered on licence and the costs, including those of training staff in their delivery, are considerable (eg Triple P or MST-CAN). Making attachment –based interventions available (1.6.4) for parents of children under 5 who have been abused or neglected would also have significant cost implications. Training all child protection practitioners in different disciplines to meet the standards in the guidance will be costly. This is in the context of significant reductions in organisational training budgets. Multi-agency training would be particularly beneficial but is seriously under-resourced at present.	Thank you for your comment. The guideline committee considered carefully the resource impact of the recommendations on home visiting (recommendations 1.5.13 to 1.5.16). This is a 'consider' rather than an 'offer' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it. However, the committee thought it was important to make this recommendation based on the evidence of effectiveness of many home visiting programmes. Although there was not conclusive evidence of cost-effectiveness, the committee also considered the potential costs of not intervening in families showing possible early signs of abuse and neglect, in terms of the potential for problems to become more serious and to result in greater service use and other costs in the future. The view of the committee was also that many local areas do already offer these interventions, and so there should not be a significant additional cost in implementing these. The recommendation that these should last for 6 months is based on the evidence reviewed by the committee. Similarly, for parenting programmes the committee carefully considered the resource implications of these recommendations (1.5.7 to 1.5.12). Again, these are 'consider' rather than 'offer' recommendations, meaning that practitioners should think about providing the intervention, rather than that they must

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					offer it.. We searched for cost-effectiveness evidence on these interventions, but none was identified that met our criteria. The view of the committee was that it was important to make a recommendation nonetheless as a way of highlighting interventions that have been shown to be effective, and promoting good practice. With regard to training – the guideline did not intend to convey that all practitioners should have all the skills and knowledge to undertake every recommendation. We have now made clearer at the beginning of that section who the intended audience is.
British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN)	Short	General	General	**Q3. What would help users overcome any challenges?** The **audience** for the guidance would benefit from further clarification. It is written as if for front-line practitioners and providers, but providers cannot implement this level of change in service delivery alone - it needs to be written in a way that also addresses commissioners from Health, LA and Public Health. In our experience those outside of health (e.g social care and education) are less aware than those in health-related disciplines that the NICE guidance is intended for them. The guidance – even the short version – is **too lengthy** for practitioners to read. It would benefit from being re-written with sections targeted at different audiences, such as commissioners of services and practitioners, having summaries of key points with the very useful links, as now, to more in depth coverage. It would be helpful to clarify the **status** of the guidance and its relationship to statutory guidance such as *Working Together.* A **coordinated and funded dissemination and training programme** is needed to ensure effective implementation of the guidance. These should be multi-disciplinary wherever possible. BASPCAN would be interested in supporting such a dissemination programme, by helping to shape the on-line materials proposed, by awareness raising and through training. A training strategy should include awareness raising; training in how to determine which interventions are likely to be most effective for which forms of abuse and in what circumstances; and, training to deliver specialist evidence-based interventions. The training needs of first line managers, supervisors, designated and named professionals should also be considered. A database or **repository of information about different evidence-based interventions** for parents and children would be of great value. This would need to be maintained and kept up to date. The California Clearing House provides an example of how this can work.	Thank you for your comment. We have now made clearer in the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8 the audience for the guideline, including which recommendations are aimed at commissioners. Commissioners are also named as an audience in the overall introduction to the guideline. We have also included in the introduction explanatory text on the status of the guideline, and its relationship to Working Together. The relevant content in Working Together 2015 are also signposted in each chapter. NICE and NCCSC support dissemination and implementation of the guidance through a range of approaches, including field outreach in the sector and supporting materials. We will be creating a suite of supporting materials for the guideline. NICE has also developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance. We agree that a repository of evidence-based interventions would be useful. This is not within NICE or the NCCSC's remit. However, we note that a What Works Centre for children's social care is currently in development.
British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN)	Short	1.2.37		The draft guidance states "Recognise that excessive physical punishment constitutes physical abuse" . It is BASPCAN's view that physical the word "excessive" should be removed completely.	Thank you for your comment. This recommendation has been removed.
British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN)	Short	1.2.9		The recommendation in 1.2.9 to consider abuse or neglect if a parent, carer, sibling or other adult in a child's household has 1 or more of the listed risk factors is unrealistic and inappropriate and displays an inadequate understanding of the nature of risk factors for (as opposed to signs/symptoms/indicators of) abuse or neglect. The presence of a risk factor increases the risk of abuse or neglect, but it doesn't necessarily raise the possibility that a child is being abused or neglected. This is particularly pertinent in relation to mental health problems. The prevalence of mental health problems in the population is such that it would be totally inappropriate for practitioners to consider abuse or neglect in every family that presented with a mental health problem. In contrast domestic violence is <u>always</u> harmful to children, therefore the presence of any indicators of domestic violence. In contrast domestic violence is always harmful to children, therefore the presence of any indicators of domestic	Thank you for your comment. We have added explanatory text in the introduction to this section to highlight that the presence of these factors increases vulnerability to abuse and neglect, but is not deterministic of abuse or neglect. Professional judgement should be used to assess the significance of these factors. With regard to domestic abuse as a

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				violence should mean that a practitioner should always suspect (not just consider) child abuse and respond accordingly."	vulnerability factor, the committee were careful to word this recommendation as 'a history of domestic abuse', in recognition of the fact that current domestic abuse constitutes abuse and neglect, as you state.
British Dental Association	Short	General	general	As with previous NICE guideline consultations – we advise NICE to consider carefully and to be very specific about the audience for their guidance/guidelines and who it is applicable to. Not all activities that are routinely described as being undertaken by a primary care healthcare practitioner or clinician will be relevant to a primary care dentist for example.	Thank you for your comment. Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action. Where necessary, we have clarified the audience of specific recommendations.
British Dental Association	Short	1	1	The title on the short version does not accurately convey the action that you wish practitioners to take. The longer version does convey however convey the action. A suggested title could be *"Recognising, assessing and responding to child abuse and neglect".* Practitioners are more likely to read/access the short version so making the title relevant is important in guiding people to follow it.	Thank you for your comment. The guideline has been named according to usual NICE naming convention.
British Dental Association	Short	1	20? There are no line numbers on page 1 past 2	The bullet point stating that this guideline is for children and young people suggests they are bound to follow the guideline. *"Children and young people at risk of, experiencing or who have experienced abuse or neglect, and their families and carers".* It is not clear however how this audience should use this guideline. This guideline is presumably for those who are able to recognise, assess and respond to child abuse and neglect and adding in the extra bullet point is unnecessary in this current form of words. If it is there for a specific reason it is not clear what that reason is.	Thank you for your comment. We have amended the wording to make it clearer that children and young people are not expected to take action as a result of the guidance, and that a specifically tailored version will be available for them in due course.
British Dental Association	Short	4	3 - 10	It is important to note that those working in or with the NHS will also follow the NHS England specific guidance to practitioners which discharges NHS England's duty for the healthcare providers they commission under the statutory guidance *Working Together to Safeguard Children*. The Care Quality Commission currently ensures that these responsibilities are discharged through their registration and inspection regime of dental practices. Given this specific guidance is in place it is vital that this NICE guideline is complementary and does not place additional burdens on practitioners making it too onerous to ensure that proper safeguards are in place for children and young people. This guides needs to make sure practitioners are not trying to remain compliant with too many overly complex different forms of information, advice and guidance.	Thank you for your comment. We have aimed to make clearer in the introduction to the guideline and at the beginning of relevant sections how the recommendations complement existing statutory guidance.
British Dental Association	Short	5	24-27	Firstly, the guideline should be very clear that this paragraph should only be relevant when abuse or neglect is suspected. Clinicians would not normally record all conversations with patients and it would not be appropriate under principles 2 and 3 of the Data Protection Act 1998. In addition for those conversations being recorded clinicians should be made aware that patients can ask for a copy of their record and that refusal to disclose that information can only be made on grounds that the information contained within would cause distress.	Thank you for your comment. The wording of this recommendation has been amended to make it clear that this only applies to conversations about suspected abuse or neglect.
British Dental Association	Short	21	22-25	Dentists are generally front-line clinicians and would not normally be responsible for effective interventions and in individual cases they would however suspect and then make a safeguarding referral to children's social care. In order to follow-up a referral or to receive a response back from children social care a timescale should be present to ensure that there is understanding on expectations from both the referrer and those receiving the referral. Lord Laming's inquiry into the case of Victoria Climbie notes the following recommendation: *"When a professional makes a referral to social services concerning the well-being of a child, the fact of that referral must be confirmed in writing by the referrer within 48 hours."* In whatever form the referral is made, it is clear that a timescale should be included for follow-up by the referring practitioner and we would argue the same should be in place for the response an actions and timescales by children's social care back to the reportee.	Thank you for your comment. This recommendation has been removed following stakeholder feedback that it did not add significantly to existing guidance.
British Dental Association	Short	22	14-25	The guideline must be clearer on who its intended audience is and make that appropriate to that audience. Not all of the bullet points are applicable to a dentist audience as it is not within their gift to ensure a safe place to live. This	Thank you for your comment. In response, we have included information at the

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				wording suggests that the audience must provide a safe physical environment. If the aim of this is to remove the element of abuse or neglect from the child or young person then that needs to be more clearly defined. Dentists are unlikely to be in a position to provide the type of emotional support for nightmares, flashbacks or self-harm and it should be clear where these are not applicable to some healthcare practitioners. Practitioners cannot follow guidance that is unclear or ambiguous.	beginning of sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8 stating to which professionals the recommendations apply. In this specific section (now Section 1.5) we have amended the wording of recommendations to make it clear at whom they are aimed.
British Dental Association	Short	23	1-7	It is not clear who the intended audience is for this section on child trafficking. This should be made clear.	Thank you for your comment. This recommendation has now been removed.
British Dental Association	Short	23	8-28	It is not clear who the intended audience is for this section on therapeutic interventions and this would not be relevant for dentistry.	Thank you for your comment. In response, we have included information on the intended audience at the beginning of this section.
British Dental Association	Short	24	1-24	Continued… It is not clear who the intended audience is for this section on therapeutic interventions and this would not be relevant for dentistry.	Thank you for your comment. In response, we have included information on the intended audience at the beginning of this section.
British Dental Association	Short	25	1-28	Continued… It is not clear who the intended audience is for this section on therapeutic interventions and this would not be relevant for dentistry.	Thank you for your comment. In response, we have included information on the intended audience at the beginning of this section.
British Dental Association	Short	26	1-29	Continued… It is not clear who the intended audience is for this section on therapeutic interventions and this would not be relevant for dentistry.	Thank you for your comment. In response, we have included information on the intended audience at the beginning of this section.
British Dental Association	Short	27	1-26	Continued… It is not clear who the intended audience is for this section on therapeutic interventions and this would not be relevant for dentistry.	Thank you for your comment. In response, we have included information on the intended audience at the beginning of this section.
British Dental Association	Short	29	3-14	Dentists working in large hospital trusts or dental hospitals will be supported if they come into contact with children or families at risk of or experiencing abuse or neglect due to the nature of the policies and procedures in place in a large secondary care setting. For primary care, some of this support described will not be applicable and therefore not available. Dentists in primary care working in smaller settings are unlikely to be involved in case management at a significant level. Small dental practices will of course have safeguarding policies and procedures in place meeting relevant CPD and CQC requirements.	Thank you for your comment. The recommendation relating to co-location has been removed. The recommendation relating to supervision has been amended to refer to supervision 'proportionate to involvement in safeguarding'.
British Dental Association	Short	34	6-10	Dentists can access training on child protection via the child protection and the dental team online training which enables practitioners to meet the competencies relevant to their role against the Safeguarding children and young people: roles and competences for health care staff, intercollegiate document (March 2014) Child protection and the dental team: https://www.bda.org/childprotection	Thank you for your comment. We recognise that there is extensive guidance on training for healthcare professionals in the intercollegiate document. This implementation priority relates particularly to inclusion of new and emerging forms of abuse within training.
British Dental Association	Short	35	1-4	It is not clear how NICE proposes to ensure that all relevant practitioners are made aware of the guidance when it is newly released.	Thank you for your comment. A communications plan is developed for all guidelines. Following publication, NICE and the NCCSC will work together to cascade information about the guideline through social care communication channels and through stakeholder organisations.
British Dental Association	Short	35	1-27	This section needs to be amended to understand the differences between a large organisation like a secondary care acute trust or a small primary care dental practice. Not all the issues listed on this page will be relevant for small dental practices.	Thank you for your comment. This is standard NICE text. These actions are advisory only and can be tailored by different organisations to their needs.
British Dental Association	Short	37	14-16	It is not clear that in its current form this guideline does offer 'what works' solutions.	Thank you for your comment. The aim of the guideline is to make evidence-based recommendations to support practice. Sections 1.5 on early help and 1.7 on therapeutic interventions in particular are based on evidence about effective interventions.
British Dental Association	Short	General	General	All throughout the short guidance, some sentences have an asterisk. There is no way to determine what the asterisk refers to either as footers or at the end of the document. They need to be removed or used as a point of clarification	Thank you for your comment. The asterisks denoted recommendations that

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				has an explanatory paragraph.	had been adopted from NICE guidance on child maltreatment. The asterisks have now been removed.
The British Psychological Society	Short	5	3	The Society believes that this section should be clear about the need to be culturally sensitive. It would be helpful for interpreters to have additional training for this work with an emphasis on the need to translate accurately. The production of developmentally appropriate visual supports to aid communication for those who are developmentally young would be a challenge. This would improve practice.	Thank you for your comment. We have added reference to cultural sensitivity in to this recommendation. We have not referred to additional training for interpreters as accurate interpretation is implied by the fact that this should not be a family member. We did not find any evidence relating to visual supports for communication.
The British Psychological Society	Full	8		Section on Response, including early help. This section includes the statement *various universal and targeted services address abuse and neglect at the early help stage*. It would be more helpful if early help were seen in the context of early intervention to prevent abuse and neglect, rather than early help being seen as an intervention in itself for abuse and neglect that has already taken place. Specific work in schools would be an important avenue for prevention work. Section on coordinating the early help offer-it would be helpful if there were a statement here to the effect that all areas should have models of early help that are embedded in practice, rather than merely commenting that the picture varies across the country. *These are delivered by practitioners in services including psychology, psychiatry, health and education* It would be more helpful if the document outlined the services involved rather than the professions, i.e. CAMHS, Educational Psychology, etc.	Thank you for your comment. This section was intended to refer to families who are showing 'early signs' of abuse and neglect (wording taken from Working Together 2015). Early help therefore comprises preventative interventions, but targeted at families who are showing indications of risk. We have amended the wording to make reference to the fact that all areas should have an early help offer, and to specify more clearly the types of practitioners who would offer specific interventions following abuse and neglect.
The British Psychological Society	Full	9 Full	 22	It would be helpful if this section had some reference to the research about why practice varies so much: as it stands it rather reads like an acceptance of high levels of variance in practice. Risk factors: - Being involved in the criminal justice system - Teenage motherhood (Brown, Cohen, Johnson, Salzinger, 1998; Furstenberg, Brooks-Gunn, & Morgan, 1987) - Economic hardship (Egeland, Carison, & Stroufe, 1993; Elder, Caspi, & Van Nguyen, 1985) http://hub.careinspectorate.com/media/279757/the-relationship-between-poverty-child-abuse-and-neglect-an-evidence-review.pdf - Being exposed to multiple risks increases vulnerability These risk factors are all around the broader impact on parenting. We believe that it would also be helpful to identify protective factors. There should be an explicit reference to the importance of a formulation based approach to understanding the links between risk factors.	Thank you for your comment. In order to ensure that the guideline was based on the most up to date evidence, the review protocols stipulated that no studies from before 2004 would be considered for inclusion. A date cut-off is used to limit the volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal framework for how social services and other agencies deal with issues relating to children. We are therefore unable to consider the studies you have cited for inclusion in the guideline which were published before this date.
The British Psychological Society	Full	10	1.1.2	We believe that the second bullet point should also include children and young people with neurodevelopmental difficulties such as: Autism, Attention Deficit difficulties, etc.	Thank you for your comment. Reference to neurodevelopmental difficulties has been added to this recommendation.
The British Psychological Society	Full	11	1,1.3 1.1.4 1.1.5	We believe that a statement about how working at a child's pace can mean that assessments may take much longer than expected and require multiple sessions, should be included. The reference is to *ensure they have privacy if they want to discuss any worries.* It should be a recommendation that privacy should be provided at the outset, since a child is likely to need to know that they are safe, before they feel they can discuss worries. Re the statement, *if your interaction with a child or young person involves touching them (for example, a medical examination) explain what you are going to do. …….. Ask for their agreement first.* This statement needs to be expanded to include an expectation that there will be a process of discussion with the young person to explain the purpose of the examination; young people are likely to be in a state of anxiety and distress and so a careful and child centred approach will be required. As it stands this statement is not child focused enough. Re the statement *ensure their words are accurately represented, using their actual words if possible.* This should be reworded so that the expectation is that the child's own words should be what is normally recorded, rather than recorded 'if possible'. Re the statement *Share reports and plans with the child or young person in a way that is appropriate to their age and understanding.* It would be helpful if this included a statement to the effect that a child/young person may need reports to be reworded to make them understandable at an appropriate developmental level, it should not be the case that adults do not share reports on the pretext that the child would not understand.	Thank you for your comments. - We agree that working at a child's pace may entail additional sessions, and this is reflected in the wording of the recommendation is section 1.7. - We have not amended the wording relating to privacy, as this will not be necessary for all conversations in all settings (for example in school) - Recommendation 1.1.5 makes reference to explaining to the young person what will happen - Recommendation 1.1.6 has been reworded to make it clear that children's own words should be used unless there is a good reason not to - Recommendation 1.1.6 has been

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			1.1.6 1.1.7		reworded to make reference to non-written formats which should assist with the issue of things being understandable at the appropriate developmental level.
The British Psychological Society	Full	12	1.1.12	We believe that this section 'working with parents and carers' should include some expectation of recognising when parents/carers have developmental or learning needs of their own, including (but not limited to) literacy difficulties, autistic spectrum difficulties, intellectual difficulties, mental health issues, etc.	Thank you for your comment. Recommendation 1.1.10 has now been amended to include reference to illness, mental health problems, disability or learning disability.
The British Psychological Society	Full	13	1.2.1	Re the section-Children and young people telling others about abuse and neglect. This section needs to include consideration that a child/young person may find it difficult to tell someone for the first time, because of a developmental, intellectual, or communication, or mental health difficulties, in relation to the other factors listed. This has Safeguarding implications.	Thank you for your comment. Reference to children's communication difficulties has been added to recommendation 1.3.1.
The British Psychological Society	Full	15	1.2.11	The Society believes that it would help if this was stated more forcefully- the experience of many practitioners is that there are significant difficulties with some practitioners understanding that risk factors can be inter-related. This can lead to a situation where individual criteria are applied to risk and the bigger picture is lost. Suggested wording: '*practitioners need to understand that risk factors can be interrelated, and that separate factors can combine to increase the risk of harm to a child or young person. Practitioners must ensure that, where there are multiple risk factors, that these are considered together, rather than as individual risk factors.'*	Thank you for your comment. The recommendation has been amended in line with your suggestion.
The British Psychological Society	Full	16	Box 2	It would be helpful to be clear that some of the behaviours listed here, when present from an early age, are indicators that could also suggest concerns about neurodevelopmental difficulties. Not all practitioners have a good understanding of typical and atypical child development. So it needs to be made clear that for some of the behaviours listed, child maltreatment is one hypothesis and there may be others. Children who have developmental difficulties and who have also been subject to child maltreatment, need assessment with regard to which behaviours are related to their difficulties and which are related to maltreatment.	Thank you for your comment. We have added text in the introduction to this section highlighting that there may be other explanations for the behaviours described.
The British Psychological Society	Full Full Full	17	1.2.14 1.2.15 1.2.18 1.2.19	Re Dissociation- there should be a statement here to the effect that if current or past abuse and neglect are discounted, with regard to a child where dissociation has been observed, then the child should be referred for a mental health assessment of the dissociation. As above, there are other reasons for these behaviours that are not related to abuse and neglect, and all should be considered. There should be some consideration that the responsibilities of young carers are such that there are effects on their presentation. The circumstances for some young carers may raise Safeguarding issues. The point needs to be made that high anxiety around medical examinations may or may not be an effect of abuse and neglect.	Thank you for your comment. We have added text in the introduction to this section highlighting that there may be other explanations for the behaviours described. Recommendation 1.2.18 is intended to highlight that in some cases, caring responsibilities may be a safeguarding issue. 1.2.19 – the term 'resistance' is intended to imply anxiety, reluctance to participate and so on.
The British Psychological Society	Full	18	22	In order to aid conceptualisation and formulation, training should be informed with regard to trauma and attachment, to avoid re traumatisation.	Thank you for your comment. We can only make research recommendations where we have specifically searched for literature and therefore know that there is a gap in available evidence. We did not search specifically for evidence on training. However, recommendation 1.8.5 relates to supervision and support for staff.
The British Psychological Society	Full Full Full Full	19	9 1.2.27 1.2.29	This could be termed a formulation based approach. It would be helpful to include an understanding that children with developmental difficulties may have particular sensory sensitivities that result in wanting to wear clothing that might be viewed as inadequate, given the weather at the time. When there may be a marked difference between language skills and the use of language, special consideration will need to be given to children with neurodevelopmental difficulties. There needs to be much more consideration re children whose development is already atypical. Not all children meet the diagnostic criteria for specific neurodevelopmental difficulties, especially if there are other significant issues in the family. There may be chaos in the family where there is also a child with neurodevelopmental difficulties. This can lead to a focus on the chaos of the household and parenting issues, over and above the child's atypical development. Chaos may be a cause of living with a child's developmental difficulties, which have not been diagnosed	Thank you for your comment. We have added reference to neurodevelopmental disorders in to the recommendations about clothing (1.3.24) and language development (1.3.29). In response to your, and others' comments, we have strengthened reference to atypical developmental and neurodevelopmental disorders throughout the guideline. The introductory text for the section on alerting features includes reference to gathering

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				and are not understood. ▯ There should be something in this section about information sharing, communicating, and working alongside other agencies.	information from other agencies.
	Short		1.3.9		
The British Psychological Society	Short Full	20	1.2.30 1.4.5 – 1.4.10 13	▯ There should be an awareness that a lack of interest or low responsiveness, passivity, or withdrawal, is seen in children with neurodevelopmental difficulties; there will be children who have such difficulties but who have not been diagnosed. ▯ There are a number of evidence-based programmes that have not been mentioned. The following organisation has a summary of these, although some of these interventions are for children and young people already in the care system: http://www.evidencebasedinterventions.org.uk/about/national-implementation-service MST-Child Abuse and Neglect – for young people age 6-17 years http://www.mstuk.org/what-mst/mst-adaptations ▯ Consideration should be given to a peri-natal/pre-birth programme for at risk or vulnerable parents to help reduce the risk of inutero traumatic exposure/assault (e.g. through substance abuse and exposure to domestic violence)	Thank you for your comment. We have added text in the introduction to the section on alerting features highlighting that there may be other explanations for the behaviours described.The recommendations on interventions are based on an extensive evidence search and review. Where programmes are not recommended, this is because they either did not meet our scope or our evidence criteria. Two of the evidence-based programmes being developed by the National Implementation Service are also mentioned in this guideline, including MST-CAN (recommendation 1.7.10) and KEEP (1.7.12). Recommendations relating to pre and perinatal interventions are given in the early help section (recommendations 1.5.13 to 1.5.16).
The British Psychological Society	Short Full	22	1.2.46 14	▯ This list should include training practitioners in typical and atypical child development ▯ It is acknowledged that young people who have experienced abuse and neglect are disproportionately represented within the juvenile justice arenas and it is important therefore that a trauma informed approach is integrated within a service delivery model.	Thank you for your comment. We have made reference to practitioner awareness of atypical child development in recommendation 1.5.6.
The British Psychological Society	Short Short Full	23	1.6.4 1.6.10 25	▯ Offer an 'attachment-based intervention'. It would be helpful to know more about any specific evidenced-based 'attachment interventions' Could refer to TEND – Video based intervention for babies and infants aged 0-4 years. http://www.evidencebasedinterventions.org.uk/interventions/tend-coming-soon ▯ MST-CAN is for children from 6-17 years ▯ An attachment and trauma informed approach is useful for all ages. Consideration should also be given to the role of sensory integration and the importance of this for children and young people who have experienced significant trauma.	Thank you for your comment. Thank you for suggesting that the guideline could refer to the TEND intervention. The webpage you have provided a link for currently provides no information about the intervention and describes it as forthcoming, but as we are aware of no empirical studies describing the effectiveness of this intervention, then it would not be eligible for inclusion, as it would not meet the criteria of the review protocols. The guideline will be reviewed for update in the future. If sufficient new evidence of effectiveness on interventions is published the guideline recommendations may be updated in response to this evidence at a future date. With regard to MST-CAN, the recommended age range in the guideline is based on the evidence reviewed.
The British Psychological Society	Short	24 Full	1.6.6 7	▯ Re *Consider child-parent psycho-therapy.* This language is woolly and could be a catch-all for un-evidenced based therapies. It is an all-encompassing term for a range of interventions. Practitioners might assert that they are delivering psychotherapy and refer to the NICE guidelines. ▯ Child-parent psychotherapy must rest on recognised training/delivery. There needs to be a range of options available. ▯ The guidelines should include broader ways to promote the welfare and recovery of children, such as milieu therapy offered through empathetic care in settings such as: home, care placements, pre-school, school, and community resources such as children's centres.	Thank you for your comment. Child-parent psychotherapy is the name of the intervention for which we found evidence. Recommendation 1.7.7 gives further detail of what is meant by this term. All the interventions in this section are those for which we found the highest-quality evidence.

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The British Psychological Society	Short	25	1.3.10 1.4.1 1.6.11	▯ It would be helpful to state where such advice can be obtained, e.g. Link nurse, child development team. ▯ It would be helpful; if an indicator of frequency of visits was stated. ▯ Refer to NIS website http://www.evidencebasedinterventions.org.uk	Thank you for your comment. The committee discussed whether to give more detail about where specialist advice can be obtained. However, the committee's view was that this was would vary in each locality. As noted above, some of our recommendations overlap with the work of National Implementation Service. This depended on what evidence was currently available for each intervention, and whether it matched our scope.
The British Psychological Society	Short	26 Parenting programmes	1.4.3 1.4.4 1.4.5-1.4.10	▯ This should include support for parents with neurodevelopmental difficulties, e.g. with autism spectrum difficulties, intellectual difficulties. ▯ This could include some training in typical and atypical child development in the skill mix. ▯ This should include consideration of the additional support needs of parents with developmental needs, or for parents where the child has additional needs.	Thank you for your comment. Recommendation 1.1.10 now makes reference to parental learning disability, and 1.1.11 makes reference to meeting the communication needs of parents.
The British Psychological Society	Short Full	27	1.4.13 1.5.1 21	▯ Practitioners at the early stage of help should have a good understanding of typical and atypical child development. ▯ It would be helpful for practitioners to have more certainty about their responsibilities, if they do not hear back from children's social care following a referral. This should not happen, but we know that it does and practitioners can be left feeling that their responsibility has ended at the point of referral. This section could include an expectation that practitioners should follow up any referral within e.g. 14 days if they have not heard back from children's social care. This would protect children from 'lost' referrals. ▯ Support for this level of intervention and the resources that will be needed.	Thank you for your comment. Reference to typical and atypical child development has now been added to this recommendation. The recommendation relating to referral has been removed following stakeholder feedback that it did not add significantly to what is in Working Together 2015. The guideline committee considered carefully the resource impact of these recommendations, and thought it was important to recommend best practice best on the effectiveness evidence. These are 'consider' rather than 'offer' recommendations, meaning that practitioners should think about providing the intervention, rather than that they must offer it.
The British Psychological Society	Short Full	28	1.5.4 11	▯ This section should include an expectation that children affected by domestic violence should be given a safe place to live. Families affected by domestic violence need access to specialist support. Professionals need to learn from the expertise of and work alongside some agencies in the voluntary sector, such as Women's Aid and Rape Crisis Centres. ▯ Re The provision of services for separated young people or unaccompanied minors or trafficked children/young people, it would be helpful to cross-reference with: Home Office Guidelines in relation to best practice. ▯ Regional and cultural considerations need to be to the fore, e.g. Paramilitary threat is especially relevant in Northern Ireland.	Thank you for your comment. We have now cross-referenced to relevant recommendations in the NICE guideline on domestic violence and abuse, and to the Department for Education guidance on child trafficking. We have not made reference to regional considerations such as paramilitary threat, but have reworded to 'protection from further abuse and neglect'.
The British Psychological Society	Short	29	1.6	The Society welcomes this clear statement of suggested approaches.	Thank you for your comment.
The British Psychological Society	Short	33	1.7.1	We believe that there should be a stronger recommendation-rather than having the same worker 'wherever possible', it would be more helpful to state that there is an expectation that children and young people should be able to expect the same professionals over time.	Thank you for your comment. We agree that children and young people should be able to expect the same professionals over time. However, the wording 'wherever possible' was intended to reflect that this is not always possible, for example if staff leave the organisation.
The British Psychological Society	Full	36	10	Due to the higher likelihood of young people from neglectful/abusive backgrounds engaging in antisocial behaviour, schools need advice to manage these young people. Additionally it is more likely they will come into contact with the Criminal Justice System. As such, it is important as outlined earlier that there is a trauma informed approach to assessment/interventions.	Thank you for your comment. The recommendations relating to therapeutic interventions aim to help children and young people recover from trauma following abuse and neglect, and so lessen the likelihood of further negative consequences such as engagement with the criminal justice system.
The British Psychological Society	Full	41	6	There needs to be a trauma pathway in CAMHS.	Thank you for your comment. We would expect that these research

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					recommendations would be applicable to CAMHS service design and delivery.
The British Psychological Society	Full	General	general	The guidelines are welcome as there is a gap in NICE provision in this area. It is evident that this has been a large piece of work, which has involved many stakeholders and a large review of literature. The guidelines should be placed within the context of the promotion of the welfare and Safeguarding of: **all** children (universality); Children in Need; and those at risk of/have been exposed to abuse and neglect. The section on communication is only written from the perspective of handling a disclosure (Section 1.1.3 – 1.1.11). The section should be broader in its remit. It should start with the factors that are helpful to children/ enable children to build up effective communication with key adults which make them feel safe enough to talk about their worries and concerns. In this, teachers, teachers' assistants, youth works, are central, on account of their contact with children on a daily basis. It is impressive that 158 out of more than 59,000 articles have been reviewed, but in Appendix A (on the website) where exclusion decisions have been made, there is a concern that the review may have inadvertently missed studies which contain information that would have been helpful to the NICE guideline and come from peer reviewed journals, such as *Child Abuse Review,* and the *Journal of Child Abuse and Neglect,* and which have excluded well regarded authors, such as Brandon and Munro. For instance, these papers seem to have been excluded from the review: *Westcott HL, and Kynan S (2006) Interviewer practice in investigative interviews for suspected child sexual abuse. Psychology, and Crime & Law: 367-82. Topic* *Westcott HL, Kynan S, Few C (2006) Improving the quality of investigative interviews for suspected child abuse: A case study. Psychology, and Crime & Law: 77-96.* It is unclear whether there has been a consideration of this systematic review: Bee, Penny, et al. "The clinical effectiveness, cost-effectiveness and acceptability of community-based interventions aimed at improving or maintaining quality of life in children of parents with serious mental illness: a systematic review." (2014). https://www.journalslibrary.nihr.ac.uk/hta/hta18080#/abstract or parenting interventions with those who have severe mental health problems, such as: Calam, Jones, Dempsey & Sadhnani (2012) in Parenting and the emotional and behavioural adjustment of young children in families with a parent with bipolar disorder. *Behavioral and Cognitive Psychotherapy,* 40, 4, p425-37. There are areas in the guidelines, which need addressing in more detail. For instance, culture needs to be mentioned more detail and in a more meaningful way; the need for anti-discriminatory practice, as well at the duty of all public services to observe the Equality Act in its service provision. It is helpful that the potential risk factor for experiencing abuse / neglect of being a child / young person with a learning / intellectual disability is acknowledged in the full guidance. In the short version of the document, we believe that it would also be helpful to recognise specifically the risk related to learning / intellectual disability (not just broadly being a disabled child) Particularly given that the presence of a learning / intellectual disability may make it more challenging to assess abuse / neglect, and therefore practitioners may need to be especially vigilant to signs of potential abuse / neglect in this group, which has been shown to be more at risk of abuse. It is also helpful in both short / full documents that the need to adapt any assessment / intervention / communication to child's level of learning / intellectual disability or developmental / communication level. It is helpful that the full document recognises that there is not evidence that parental learning/intellectual disability is a known factor in child abuse/neglect. However in clinical practice there is often an assumption by some professionals that parents with learning disabilities may be more likely to abuse/ neglect their children. Parents with learning/intellectual disabilities come into contact with children's social services more frequently. They may have a range of other difficulties, such as debt/accommodation problems, which may be risk factors for child abuse and neglect. The Guidelines should direct practitioners to good practice guidance in this area. References: the recent update from Working Together with Parents Network (DoH 2016) and the Good Practice Guidance on working with Parents with a Learning Disability (DfES 2007). The document does not really explore systems in a meaningful way and this is important in order to ensure that systems (whether they be at a school or community or institutional or familial level) are resilient and that they are helped to be safe systems. The work of James Reason on safety would provide helpful guidance, as would Vincent and	Thank you for your comments. Recommendations 1.1.2 to 1.1.11 aim to cover good practice in all interactions with children and young people, parents and carers, and are not limited to disclosure. Westcott, Kynan and Few (2006) was screened on full text but was excluded as it relates to training, which is outwith the scope of the guideline. Westcott and Kynan (2006) was screened on full text but not included as this approach is already recommended in government guidance on Achieving Best Evidence. Thank you for drawing our attention to the study by Bee et al. Due to the wealth of evidence in this area, we applied strict screening criteria for the inclusion of evidence. This study was screened, but it was excluded on the ground that the population of interest was not specifically children and young people at risk of, or experiencing, abuse and neglect. We recognise the links between these two populations, but were also mindful that there are children whose parents have mental health issues who are not at risk of, or experiencing abuse or neglect. The study by Calam et al was also considered, but also excluded on the grounds that the population of interest was not specifically children and young people at risk of, or experiencing, abuse and neglect.. The guideline's scope is limited to providing recommendations where there is research-based evidence to support the recommendation. We have therefore not referred extensively to other good practice guidance, except key statutory guidelines and advice. Reference to religious and cultural beliefs has been added to recommended 1.1.3 and 1.1.10. Recommendation 1.2.3 has been amended to read 'Mental health problems which have a significant impact on the tasks of parenting.'

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				Amalberti (2016) *Safer Healthcare.* There could be more emphasis on the impact of professional decision making as outlined in the work of Eileen Munro; the importance of sense-making (psychological formulation), dealing with uncertainty and suspicion and decision-making cannot be over-stated. 1.2.6 – This point should be qualified as there may be times when people have to act without the immediate knowledge and consent of the victim. There should be more about risk factors and particularly the impact of economic deprivation It is important to state that the term 'mental health problems' often covers a broad area; it is important to clear that the document is referring to mental health problems which impact on the tasks of parenting in a significant way – many people with parental mental health problems parent well. The document could be more confident in its coverage of FGM and honour/shame based violence. It could be more confident in its position about the abuse of boys, especially given recent reports about non-recent abuse within sport. Dealing with disclosures of Non-Recent Abuse appears to be an omission in the guidelines and I suggest that the documentation should refer to the BPS (2016) guidance document on the management of non -recent abuse. Please see: https://beta.bps.org.uk/news-and-policy/guidance-management-disclosures-non-recent-historic-child-sexual-abuse-2016	
The British Psychological Society	Full	General	general	**Areas which will have the biggest impact on practice and be challenging to implement, for whom and why?** Systems must be adequately resourced and there needs to be a much firmer emphasis on promoting healthy and resilient organisations, particularly in relation to staff wellbeing and stress (in line with Health and Safety Executive Management Standards). A healthy workforce embedded in a safe and reflective organisation, is likely to provide high quality intervention to the population it serves. Similarly, the state of public services needs to be healthy enough that people can access the help they need across the piece. In practice this is currently difficult to achieve, particularly within mental health settings, which are now nationally recognised to be under-funded and under considerable strain. It is clearly challenging to implement integrated working within the current funding climate, and one where there is a reduction in investment in public service staff training. It is important to continue to offer adequate investment in training, an emphasis on values based organisational culture and to promote joint working across agencies to create a smooth pathway for children and young people to access the help they need and the required point in time. It must be acknowledged that to fail to do this, fails our responsibilities to safeguard children and young people.	Thank you for your comments. We recognise the resource constraints in the sector at present. However, the committee thought it was important to continue to recommend best practice as a way of improving outcomes for children and young people.
The British Psychological Society	Full	General	General	**Would implementation of any of the draft recommendations have significant cost implications?** The costs need to be considered in terms of the intergenerational continuity of child abuse, as well as the long-term consequences of abuse for individuals, families and communities. Children and young people at risk of abuse are more likely to have mental health needs and conduct problems. Not addressing the risk factors will impact on costs to other systems, such as schools and the care system, and increase need for other interventions. Whilst the costs of some of the more intensive systemic interventions can seem expensive when compared to other types of treatment such as parenting interventions or individual therapy provided by CAMHS (Hughes et al, 2012). This is significantly less than the costs of placement. The cost per placement for a child looked after in foster care is around £25,000. The cost rises significantly for a child in a secure children's home (£125,000) or a child looked after in secure accommodation (£134,000). These figures do not include savings in terms of antisocial behaviour, education or custody, as well as other mental health costs. The mental health needs of young people in the care system are extremely high. There is evidence to suggest that going into the care system has a negative impact on a young person's mental health (Ford et al, 2007). With this in	Thank you for your comment. The guideline committee were also of the view that addressing child abuse and neglect was likely to lead to cost savings in the longer term.

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				mind: working with the family systems and preventing young people from entering the care system is one of the clear demonstrations of how an evidence-based intervention effectively impacts positively on mental health outcomes. If there is a true commitment to safeguarding, then these changes should invest in universal services, which are free at the point of access, based on need. This would entail a reversal of some of the current Government policies on reducing funding to Local Authorities, who are having to make very tough decisions about how to adequately fund even statutory services. In such a climate, whole population resources, such as school building, children's centres, and libraries, are being cut and the result is that community cohesion and resilience is diminished, with the most deprived and vulnerable bearing a disproportionate impact of the services lost. The projected long term costs of under-funding such services is likely to lead to higher inequality and there is robust evidence that this has long term social and economic costs, e.g. Wilkinson and Pickett (2012). These may well be higher than the costs of community investment at an earlier stage.	
The British Psychological Society	Full	General	general	**What would help users overcome ant challenges? (For example, existing practical resources or national initiatives, or examples of good practice).** We believe that there must be adequate funding across services in order to make these guidelines workable, and to develop them further over the coming years. There are a number of evidenced-based interventions available that work with families where a young person is at risk of care or custody or already in the care/secure system. Examples of good practice should be drawn upon and the existing evidence base should be used. There has been a history of putting high levels of funding at a Government level into interventions that have not drawn upon the evidence (e.g. the Troubled Families Agenda) and Pause (intervention for parents who have had multiple children taken into care) and this funding could be better used to support the development of interventions with an evidence base more widely. There is an idea that attachment models use an evidence-based theory. Whilst the theory is well established in the literature, the translation of this into an intervention has less evidence. Share good practice of small authorities joining up with neighbouring authorities. A longer term vision, which promotes early intervention, through reinvestment in public services, such as children's centres and the expansion and investment of health visiting are crucial. Equity of funding to all schools is needed with proper resources being allocated for teachers. Proposals to increase the school curriculum to include mental health, wellbeing and resilience are welcome, but there must be adequate funding and training of staff to deliver it. An investment in creating safer communities/ community resilience would be welcome – with one of the key aims of such intervention being to build and sustain social cohesion and reduce social inequality.	Thank you for your comment. This guideline has drawn on the best available evidence in recommending the interventions in this guideline. We agree that more funding is required to develop interventions, as reflected in the research recommendations.
The British Psychological Society	EIA	General	General	**Equality Impact Assessment** The Society welcomes that 45 stakeholder organisations responded and the list of stakeholders is impressive – it may be useful to include groups such as: Women's Aid, Rape Crisis, Oxford Against Cutting (working around FGM); Karma Nirvana (working against Forced Marriage and Honour/Shame Based Violence) and Southall Black Sisters (working actively on a host of issues facing women, such as domestic violence) in the discussions on this documentation It is welcome that NICE took advice on issues where there was a dearth of research evidence. This lack of evidence means that there are certain groups who are neglected. The EIA should reflect and acknowledge this. The guidelines should emphasise that it is good practice for organisations and clinicians to make special attempts to meet the unmet needs of particular populations. Culture is not mentioned enough in the document. Certain populations are under-represented in this population, such as Southern Asian people, who may face particular stigma in seeking help, related to concepts of honour and shame within their communities. As such, specialised sources of help need to be available in order to help people to feel safe to come forward. In 2015, the UK charity Karma Nirvana (specifically supporting victims and survivors of Forced Marriage and Honour/shame Based Abuse) reported that they had received 6,700 calls to their helpline. (Karma Nirvana, 2015) The EIA states that disabled children are not considered to be a particularly vulnerable group; it is important to recognise that disabled people still suffer structural disadvantage and so there may be particularly vulnerabilities attached to having a disability. These vulnerabilities will likely be an interaction between a number of factors, e.g.	Thank you for your comment. Karma Nirvana provided expert witness testimony to the guideline, but did not sign up as a stakeholder group. The other groups you mention had also not signed up as stakeholder groups for the guideline. We did review evidence relating to South Asian communities and honour-based violence, and also invited a representative from Karma Nirvana as an expert witness on forced marriage. Recommendation 1.3.8 refers to female genital mutilation. Recommendation 1.8.3 refers to honour-based abuse (including forced marriage) and breast ironing. In response to your feedback, we have added further references to culture and belief to recommendations 1.1.3 and 1.1.10. Recommendation 1.2.7 and the Equality Impact Assessment both highlight disabled

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				disability, poverty, alcohol/drug misuse, unsafe environments, the nature of the disability and the child's developmental stage. There is a danger of making disabled people's needs invisible by not addressing this. The guidelines could do more to be clear about the parameters and limitations of the current evidence base (even in the short document), which then helps to contextualise why they make recommendations about help for girls and not for boys. We need innovation and targeted research to ensure that 'invisible' groups are recognised and offered help too. The suggestions about areas needing further research at the end of the document are welcomed by the Society. In terms of Socio-Economic Status (SES), there is evidence on the role of SES in health and the guidelines falls far short in recommending whole population strategies – early intervention with individuals and their families is valued, but should be one of a range of measure to prevent abuse. Michael Marmot's work (Marmot Review, 2010) provides compelling evidence on the impact of health inequality upon health (both physical and mental health). Again the document highlights that there is a lack of evidence meeting criteria, on meeting the needs of unaccompanied asylum seeking children and children who have been trafficked. This lack of evidence relates to a lack of intervention for and the invisibility of these vulnerable groups – it does not equate to lack of need. There is a growing body of evidence on trauma informed practice and it is welcome that the document does contain some reference to e.g. Trauma Focussed CBT for PTSD, and trauma pathways in CAMHS, but it has not addressed other types of trauma based intervention, such as Narrative Exposure Therapy. It would be helpful to produce a guide on 'What works for who? And when?' We believe that NICE should also highlight the need for Practice Based Evidence (PBE) to be developed in areas which are currently under-researched, to try to break this cycle of 'low evidence; no recommendation' for invisible and vulnerable groups. Point 3.4, states that the committee have sought not to disadvantage one group over another. However, the guideline is by nature descriptive and so will reflect current variability in the evidence base; this in turn shows how some children and young people remain invisible. It could make a clearer statement about this and this would be welcomed. In terms of other protected characteristics, the guidance should highlight those who are pregnant (for instance, the plight of increasing numbers of homeless women who may be pregnant and unable to access refuges due to Governmental cuts to Local Authority funding).	children as being at increased risk of abuse and neglect. We have added information in the introduction to the guideline about the evidence that has been used to develop the guideline.
The British Psychological Society	References	General	general	References: BPS (2016) Guidance document on the management of disclosures of non-recent (historic) child sexual abuse. Leicester: BPS. Calam, Jones, Dempsey & Sadhnani (2012) in Parenting and the emotional and behavioural adjustment of young children in families with a parent with bipolar disorder. *Behavioral and Cognitive Psychotherapy,* 40, **4**, 425-37. Karma Nirvana (2015) Poster report '*Our shocking statistics in 2015*'. DOI accessed on 12 March, 2017: http://www.karmanirvana.org.uk/useful-resources/ Marmot, M. (2015) *The Health Gap*. London: Bloomsbury. Reason, J. (2000) Human Error: Models and Management. *British Medical Journal*, ***320****,* 768–70. Schofield and Beek, (2004) Promoting Attachment and Resilience-Secure Base Model', BAAF Vincent, C. & Amalberti, R. (2016*) Safer healthcare strategies for the real world.* Springer. Westcott, H.L., and Kynan, S. (2006) Interviewer practice in investigative interviews for suspected child sexual abuse. Psychology, and Crime & Law: 367-82. Topic Westcott, H.L., Kynan, S., Few, C. (2006) Improving the quality of investigative interviews for suspected child abuse: A case study. Psychology, and Crime & Law: 77-96. Wilkinson, R.G. & Pickett, K. (2009). *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London: Penguin.	Thank you for your comment, and for providing a list of references to studies you have alluded to in your submission. In our previous responses, we have explained why they were considered not suitable for inclusion in the guideline. • BPS (2016) could not be considered, as it is not a report on empirical research. • Calam et al. (2012) was considered, but could not be used as the population of interest was not specifically children and young people at risk of, or experiencing, abuse and neglect. • We were unable to access any empirical research data using the weblink to Karma Nirvana. • Marmot (2015), Schofield & Beek (2004), Vincent & Amalberti (2016) and Wilkinson & Pickett (2009) could not be considered, as the review protocols precluded the use of books. • Reason (2000) could not be used, as the review protocols precluded the use of studies pre-dating 2004. • Westcott, Kynan and Few (2006) was screened on full text but was excluded as it relates to training, which is outwith the scope of the guideline.

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					Westcott and Kynan (2006) was screened on full text but not included as this approach is already recommended in government guidance on Achieving Best Evidence.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	General	general	Overall, these are excellent and a great example of how to express guidelines succinctly, using everyday language. The section on therapeutic intervention is timely and important. A 'strength-based approach' is used throughout.	Thank you for your comment.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	4	3	Suggest add *What to do if you're worried a child is being abused* (HM Government, March 2015)	Thank you for your comment. Reference to this document has now been added to the introduction to the short and long guidelines.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	5	3	Excellent advice on hearing the child's voice, expressed clearly and succinctly	Thank you for your comment.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	5	7	I agree with using open questions *but* survivors state that, at times, they wished they had been asked more leading questions. I note the research question surrounding this which is well conceived and expressed. I will expand on this when I discuss 1.2.4 below.	Thank you for your comment. The committee considered this issue carefully, and were particularly mindful of the importance of any conversations not jeopardising any later investigations, as set out in **Achieving best evidence in criminal proceedings**
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	5	24	The practical application of this within normal working practice, i.e school nurses, ED staff, sexual health etc would need specific protocols and very clear guidance for providers to work with a) records that are often electronic and b) the non- electronic records tend to form part of a record which the young person has no access to without submitting an access to records request.	Thank you for your comment. We would envisage that practitioners could develop and agree electronic records with children and young people.
Birmingham South Central CCG & Birmingham Cross City CCGs	short	6	6	I am not sure what "unrealistic expectations" would be in the context of child safety	Thank you for your comment. This recommendation was based on feedback from the children and young people's expert reference group. They thought it would be helpful to know what services could and could not offer. For example, knowing that you will see your social worker, but it might not be every day because they have other children and young people to see.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	6	10	This recommendation may be challenging in terms of advice to practitioners on how to provide a child or young person with contact details, particularly through phone, email or social media. This has been hinted at in the guidance but good practice guidance might need to be issues by Trusts or NHSE.	Thank you for your comment. We agree that profession-specific guidance to help implement these recommendations may be helpful.
Birmingham South Central CCG & Birmingham Cross City CCGs	short	8	14	1.2.2 – 1.2.3 are excellent and show good use of everyday language, especially the use of "telling others" instead of 'disclosing'. With respect to 1.2.4., one *might* have to resort to a more leading question style to overcome the child's denial, shame or inability to find words when words have been stolen from her. For example, one could say, "I know that this is very difficult for you …. But I know that children in your situation are sometimes being touched in places that feels wrong but that they can't find the words to say it'. 'So, I can say it for you and you can tell me how true that might be for you". I note the research question around this issue. I don't think such an approach would contaminate a 'Best Evidence' interview.	Thank you for your comment. The committee considered this issue carefully, and were particularly mindful of the importance of any conversations not jeopardising any later investigations, as set out in **Achieving best evidence in criminal proceedings**
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	11	5	Question 1, 2: This recommendation on the identifying 'dissociation' in a child might have implications in terms of choosing the right instrument to use and in training professionals on how to use such an instrument or to have the skills to identify dissociation. In my opinion, it is a difficult concept to grasp.	Thank you for your comment. The recommendation includes a description of how dissociation may manifest, to help practitioners in recognising this.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	11	11	? add depression to list	Thank you for your comment. We did not review evidence about the association between mental health problems and abuse or neglect, on the grounds that children and young people with diagnosable mental health problems would receive treatment and support. We are therefore unable to make specific reference to depression.

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Birmingham South Central CCG & Birmingham Cross City CCGs	Short	16	17	Question 1: 'Completing a standard questionnaire to screen for risk factors' in primary care might be difficult to implement. Which risk factors do you choose when no one risk factor is necessary or sufficient to predict child maltreatment, and with factors such as alcohol and drug misuse having very high base rates in the community?	Thank you for your comment. We have removed reference to screening in this recommendation.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	18	1	Question 1: Add a sentence to include that it is important to be aware of parents/carers own learning experiences and assess if there is any suggestion of unidentified learning needs that could impact upon parenting and cognition. This is important as some adults may not have had own educational needs addressed in childhood and can impact on their abilities to improve parenting without the right support. Professionals may find this a challenge to raise.	Thank you for your comment. Recommendation 1.1.10 now makes reference to parental learning disability, and 1.1.11 makes reference to meeting the communication needs of parents.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	18	20	"Reinforce that they have a right to talk about child abuse and neglect". I agree but they might find words and drawing difficult. It is therefore incumbent on professionals to 'feel the child's 'lived experience': what would it be like to be in that child's household? (See also 19.3)	Thank you for your comment. Recommendation 1.4.1 highlights the importance of observation in addition to communicating directly with the child or young person.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	19	9	It is important to add that assessments of children and families require review on a regular basis as circumstances change and risks to children can reduce or increase	Thank you for your comment. Reference to review of assessments has been added to recommendation 1.4.3.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	19	21	Question 1: Home visiting to families at risk of abusing or neglecting their children for at least 6 months would be beneficial as research supplied suggests. However, the professional would need to have clear objectives for the work with families in that time and mechanisms for close supervision and monitoring if to avoid pitfalls of collusion and drift. In 1.4.1, and in other places, you have set age limits on intervention. I presume that that is in accordance with best evidence. Question 1 and 2: These programmes are essential ***but*** there are major cost and staff implications within primary care and early years as many of these programmes are being decommissioned by cash-strapped local authorities, despite the strong evidence base and many of the local centres are also closing. Unless this short-sighted thinking is addressed, this recommendation will not be carried through in many local authorities.	Thank you for your comment. We agree that professionals would need clear objectives within the context of home visiting, linked to the components of the intervention set out in recommendation 1.5.15. The guideline committee considered carefully the cost-effectiveness and resource impact of the recommendations on home visiting. This is a 'consider' rather than an 'offer' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it. However, the committee thought it was important to make this recommendation based on the evidence of effectiveness of many home visiting programmes, as a way of encouraging good practice. Although there was not conclusive evidence of cost-effectiveness, the committee also considered the potential costs of not intervening in families showing possible early signs of abuse and neglect, in terms of the potential for problems to become more serious and to result in greater service use and other costs in the future. The view of the committee was also that many local areas do already offer these interventions, and so there should not be a significant additional cost in implementing these. The recommendation that these should last for 6 months is based on the evidence reviewed by the committee. Where age limits are recommended, this is based on the evidence review. Explanatory text to this effect has been added to the introduction. The committee considered carefully the resource impact of home visiting. Their view was that it was important to recommend this best practice intervention.
Birmingham South Central	Short	20	9	Question 1: This section suggests that the home visiting programme should be completed by a worker trained to deliver	Thank you for your comment. We have

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CCG & Birmingham Cross City CCGs				that particular home visiting programme. This needs clarification as to whether one worker delivers all that is needed such as parenting, behaviour and parental substance misuse therapy/ mental health care as it is unlikely that this can be completed by one worker. If this is not the intention of the statement then it should be altered to reflect the multi-agency/multi-disciplinary approach that would be required in the home visiting programme.	amended the wording of recommendation 1.5.15 to make it clear that the home visiting worker would be expecting to explore issues such as substance misuse as far as they relate to parenting, but also to support parents to access other services.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	20	13	Question 1 and 2: Again, many of these parenting programmes are being decommissioned. Those that are commissioned (Tripe P or Incredible Years) have a sound evidence base but are generally social-learning theory-based and do not reach those where emotional responsiveness is the main concern. Thus, some areas are using programmes such as 'Tuning In For Kids' that, in small trials, can reach carers at risk for harming their children. Any new introduction of such a programme should be subjected to a RCT, against an established programme, using 'social equipoise' as a guiding principle. This will have cost implications but this is where the thrust of early intervention should be, in addition to social and material support (p21, line 4).	Thank you for your comment. This recommendation was based on US and Australian RCT evidence suggesting that parenting programmes based on social learning theory are effective amongst parents who are at risk of abusing or neglecting their children. The guideline committee considered carefully the applicability of this evidence to a UK context, and decided that this evidence was applicable to a UK setting. We agree that gathering further UK RCT evidence would be beneficial.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	20	21 and 24	Again, there will be cost implications in implementing these evidence-based programmes.	Thank you for your comment. The guideline committee considered carefully the cost-effectiveness and resource impact of the recommendations on parenting programmes. These are 'consider' rather than an 'offer' recommendations, meaning that practitioners should think about providing the intervention, rather than that they must offer it. However, the committee thought it was important to make the recommendations based on the effectiveness evidence as a way of promoting good practice. Although there was not conclusive evidence of cost-effectiveness, the committee also considered the potential costs of not intervening in families showing possible early signs of abuse and neglect, in terms of the potential for problems to become more serious and to result in greater service use and other costs in the future. The view of the committee was also that many local areas do already offer these interventions, and so there should not be a significant additional cost in implementing these.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	21	4	Question 3: Add in a sentence to include; offer appropriate resources to parents that are tailored to differing levels of learning need and are culturally sensitive. This would help overcome barriers to parental/carer co-operation with professionals	Thank you for your comment. Thank you for your comment. Recommendation 1.1.10 now makes reference to parental learning disability and cultural and religious needs, and 1.1.11 makes reference to meeting the communication needs of parents.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	21	19	Question 3: Professionals lack of resource within areas such as primary care have led to beliefs that GP's are not able to act as lead professionals in early help even though they are in a strong position to identify families in need of support. They also often provide early help and signposting which is not being evidenced. (Particularly for families of school age children). Can NICE offer any evidence/ or views nationally of the usefulness of additional roles to be developed across GP practices in order to take on the lead roles with the primary care health team supporting with EH plans? This document seems such a good opportunity to highlight the potential of such roles in primary care around early help.	Thank you for your comment. We did not find any evidence relating to specific roles within primary care. We hope that this guideline will support GPs and other professionals to provide evidence-based early help.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	22	26	I think a short statement about how toxic domestic violence is for mother and child would not go amiss. It is in the evidence section.	Thank you for your comment. Recommendation 1.6.3 now signposts people to the NICE guideline on domestic violence and abuse, which includes details recommendations on this topic.

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Birmingham South Central CCG & Birmingham Cross City CCGs	Short	23	8	Question 1&2: This section on therapeutic intervention is most welcome and recommends specific therapeutic modalities that have a sound evidence base. However, they might well be a challenge to implement and have cost implications as they are not widely available, will require training in many instances, and the appointment of psychotherapists and trained social workers who can deliver these therapies. There might be pressure on CAMHS waiting times and these are already too long. Despite this, I feel these recommendations should stand as an acknowledgement of where we should be in therapeutic intervention for vulnerable and traumatised children and young people with emotional dysregulation and attachment difficulties. Opportunities for properly conducted RCTs should always be considered but these would need to be multicentre.	Thank you for your comment. The guideline committee carefully considered the resource implications of the therapeutic interventions. The committee considered cost-effectiveness evidence where available, as well as economic modelling in relation to recommendation 1.7.10 (SafeCare) and recommendation 1.7.17 (CBT), and cost-effectiveness evidence in relation to recommendation 1.7.19 (group psychotherapy). Where cost-effectiveness evidence or economic modelling was not available, the committee made 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence as a means of promoting good practice. 'Consider' means that practitioners should think about providing the intervention, rather than that they must offer it. The committee also took in to account the availability of therapeutic interventions. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Given all these considerations, the recommendations were felt by the GC to be aspirational but achievable. There are a number of research recommendations specifying well-designed studies on intervention effectiveness (e.g. 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 2.13, 2.14, 2.15)
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	23	27 (attachment-based intervention in the home)	I am concerned that the cost of delivering psychotherapy interventions in the home is unrealistic nationally. I'm not sure that there are enough trained professionals to provide this and would be an expensive resource and difficult to sustain.	Thank you for your comment. The recommendation to provide attachment-based therapy in the home (now recommendations 1.7.4 and 1.7.5) was adapted from the NICE guideline on attachment. The guideline committee carefully considered the resource impact of this recommendation. We searched for evidence on cost-effectiveness, but found no evidence meeting our criteria. However, the committee thought that it was important to make this recommendation to highlight best practice for this group, based on the effectiveness evidence. This is an 'offer' recommendation for consistency with the attachment guideline. The guideline committee discussed the availability of these types of interventions, and acknowledged that there may be variability in terms of availability of staff to deliver these interventions across the country. However, the committee's view was that the guideline could be used to encourage commissioning and greater consistency of provision.
Birmingham South Central	Short	24	10, 11 and 22 (child-	The above comments in point no 21 applies to individual psychotherapy the Cicchetti Toth model of parent child	Thank you for your comment. The

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CCG & Birmingham Cross City CCGs			parent psychotherapy)	psychotherapy	recommendation to provide child-parent psychotherapy in the home (now recommendations 1.7.6 and 1.7.7) is based on the available evidence. The guideline committee considered carefully the resource implications of this recommendation and thought the effectiveness evidence was sufficient to recommend this intervention (which is also recommended in the NICE guideline on attachment). This is a 'consider' recommendation, indicating that practitioners should think about providing the intervention, rather than that they must offer it.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	24	13 (child-parent psychotherapy)	As discussed in point 22	Thank you for your comment. The recommendation (now recommendations 1.7.6 and 1.7.7) to provide child-parent psychotherapy in the home is based on the available evidence. The guideline committee considered carefully the resource implications of this recommendation and thought the effectiveness evidence was sufficient to recommend this intervention (which is also recommended in the NICE guideline on attachment). This is a 'consider' recommendation, indicating that practitioners should think about providing the intervention, rather than that they must offer it.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	25	11 (parent-child interaction therapy)	The comments in point no 21 applies to parent-child interaction therapy	Thank you for your comment. The guideline committee considered carefully the resource impact of this recommendation (now 1.7.11), and thought the effectiveness evidence was sufficient to recommend this intervention. This is a 'consider' recommendation, indicating that practitioners should think about providing the intervention, rather than that they must offer it.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	25	17 (MST)	The comments in point no 21 above applies to MST, although this is far more widely available in the NHS and third sector.	Thank you for your comment. The guideline committee considered carefully the resource impact of this recommendation (now 1.7.14), and thought the effectiveness evidence was sufficient to recommend this intervention. This is a 'consider' recommendation, indicating that practitioners should think about providing the intervention, rather than that they must offer it.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	25	22 (MST)	As discussed in point 22	Thank you for your comment. This recommendation (now 1.7.14) suggests that the intervention should be delivered in 'the home or in another convenient location'. This gives providers some flexibility in the location of delivery.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	25	23 & 24 (MST)	Question 1&2: I am concerned that an on call service round the clock would be too costly for a lot of areas.	Thank you for your comment. This recommendation was based on effectiveness evidence. We searched for evidence of cost effectiveness but none meeting our criteria was available. However, the guideline committee considered the resource impact of this element of the recommendation (1.7.14).

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					Their view was that this is a key component of the support provided by the intervention. The view of the committee was that the on-call service does not necessarily need to comprise trained professionals, but rather to act as a 'helpline' function. The committee also considered the availability of therapeutic interventions. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	25	26 (attachment based)	As discussed in point 22.	Thank you for your comment. The recommendation (now 1.7.8) to provide attachment-based therapy is based on the available evidence. The guideline committee considered carefully the resource implications of this recommendation and thought the effectiveness evidence was sufficient to recommend this intervention. The committee recognised that this intervention may not be available in all areas, but hoped that this guideline may help to influence commissioning. This is a 'consider' recommendation, indicating that practitioners should think about providing the intervention, rather than that they must offer it.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	26	28 (CBT)	The comments in point 21 apply to trauma-based CBT, although it has been commissioned in some areas.	Thank you for your comment. The guideline committee considered carefully the resource impact of this recommendation (now 1.7.17). Economic modelling undertaken as part of developing the guideline suggested that this intervention was cost-effective at the NICE-recommended threshold of £20,000-£30,000 per Quality-Adjusted Life Year (QALY). The view of the committee was that trauma-focused CBT was a relatively widely available intervention. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	27	8 (LTFI)	The comments in point 21 apply to "Letting the Future In".	Thank you for your comment. The guideline committee considered carefully the resource impact of this recommendation (now 1.7.18), and thought the effectiveness evidence was sufficient to recommend this intervention.. The committee recognised that this intervention may not be available in all areas, but hoped that this guideline may help to influence commissioning. This is a 'consider' recommendation, indicating that

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					practitioners should think about providing the intervention, rather than that they must offer it.
Birmingham South Central CCG & Birmingham Cross City CCGs	Short	29	14	CPD must also involve peer review.	Thank you for your comment. This recommendation sets out the functions that supervision should fulfil, based on the evidence we reviewed. We have not specified the mechanisms by which these should be achieved, so this recommendation would not preclude use of peer review.
British Society of Paediatric Dentistry	Short	7-17		We think this section will help dental professionals recognise abuse and neglect, when used in conjunction with NICE CG89.	Thank you for your comment.
British Society of Paediatric Dentistry	Short	10-16		Please clarify the meaning of using the * symbol on these pages.	Thank you for your comment. The asterisk indicated that the recommendation had been taken from the NICE guideline on child maltreatment, as stated in the introduction. These have now been removed.
British Society of Paediatric Dentistry	Short	18	1-5	1.3.2 Does this apply only to the lead practitioner's assessment? Or to all assessments made by any professionals working with children? Please clarify. Although desirable, we think it would be unrealistic to expect dental professionals to collect and analyse information about all significant people in the child's care environment, and then to keep it updated.	Thank you for your comment. We have aimed in the introductory text to section 1.4 to make clear that these recommendations apply to both early help and statutory assessments, and that early help assessments can be undertaken by anyone in the lead professional role.
British Society of Paediatric Dentistry	Short	19	7	1.3.8 Does this apply only to the lead practitioner's assessment? Or to all assessments made by any professionals working with children? Please clarify. Although desirable to focus attention equally on male and female parents and carers, as dental professionals we would not always have this opportunity. To achieve this would place unreasonable demands on parents to attend or on services to provide additional appointments, requiring considerable additional resources.	Thank you for your comment. We have aimed in the introductory text to section 1.4 to make clear that these recommendations apply to both early help and statutory assessments, and that early help assessments can be undertaken by anyone in the lead professional role.
British Society of Paediatric Dentistry	Short	19	18 -	1.4 Although not directly relevant to the services we provide, knowledge that families should receive evidence-based support is likely to encourage dental professionals to report early concerns. This will have resource implications for dental services as referrers and for the services which will receive the additional referrals.	Thank you for your comment. We recognise that these recommendations are likely to have resource implications, but also note that evidence-based early help is recommended in statutory guidance (Working Together 2015) as well as in this guideline.
British Society of Paediatric Dentistry	Short	22	4-13	1.5.2 Better multi-professional communication is required. Often, even when we know families well and may be working with the child regularly, dental professionals are forgotten and not invited to contribute to assessment or planning. This needs to be added to social care professionals' training. However, if dental professionals are invited to attend more case conferences and contribute reports this will also have training implications for dental services and require additional resources.	Thank you for your comment. Guidance relating to multi-agency working with regard to case conferences is given in Working Together 2015, so has not been repeated in this guideline.
British Society of Paediatric Dentistry	Short	23	8 -	1.6 Although not directly relevant to the services we provide, knowledge that children, young people and families should receive evidence-based interventions after abuse and neglect is likely to encourage dental professionals to make child protection referrals when they have concerns. This will have resource implications for dental services as referrers and for the services receiving additional referrals.	Thank you for your comment. The guideline committee considered carefully the resource impact of the recommendations, including based on cost-effectiveness evidence and economic modelling.
British Society of Paediatric Dentistry	Short	27	28	1.7.1. We endorse the recommendation that children work with the same professionals over time when possible. In our context we are aware that current service pressures and the need to make efficiency savings mean that professionals are frequently moved or have their duties changed such that continuity of care is disrupted. As written, it is unclear whether this recommendation is intended to apply to all contexts – employers may wriggle out of this unless it is made clearer.	Thank you for your comment. We have added text at the beginning of this section (now 1.8) to make it clear that these recommendations are particularly aimed at : • Strategic commissioners of services for children and young people who have been abused or neglected. • Social workers and others coordinating support for children and young people, to help them decide what services to refer children and young people to.

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					• Child and adolescent mental health practitioners (psychologists, psychotherapists, psychiatrists), practitioners in specialist family intervention teams (for example social workers) and voluntary sector agencies.
British Society of Paediatric Dentistry	Short	28	24	1.7.5 Whilst desirable in principle it is difficult to see how co-location of dental services with other agencies could be achieved at present without significant service reorganisation. On checking the Full Guideline it appears that this applies to social care services, not all professions working with children – please clarify in the Short Guideline.	Thank you for your comment. The recommendation in relation to co-location has now been removed.
British Society of Paediatric Dentistry	Short	29	8-14	1.7.8 Access to good quality safeguarding supervision is not yet embedded in our professional practice. Additional resources are needed to achieve this.	Thank you for your comment. We recognise that additional resources may be required to implement this best practice recommendation, but the view of the committee was that this was an important element of good practice.
British Society for Paediatric Endocrinology and Diabetes (BSPED)	Full	general	general	There is no specific mention of fabricated and induced illness as a form of child abuse. It is mentioned in general terms (eg in section 1.3.1, to highlight an example of when concerns should not be discussed with parents) but not listed as something to consider. In section 1.2.41-1.2.45 (providing access to medical care or treatment), I feel that this should also include a paragraph on considering fabricated and induced illness in a child who is reported to have symptoms which do not fit with what is being observed. It is also important that children who have a known, genuine medical condition can also be subjected to fabricated and induced illness, such as by having medication deliberately withheld or increased by carers. The RCPCH have a good document on this.	Thank you for your comment. Fabricated and induced illness is covered by the NICE clinical guideline on When to suspect maltreatment. We have added a recommendation (1.3.44) signposting to the relevant recommendations on fabricated and induced illness in the clinical guideline.
Child Protection in Education - CAPE	Full	General	General	The full version of the document is too long and at 581 pages it is far longer than any of the statutory guidance which currently applies to Education settings i.e. Keeping Children Safe in Education 2016 and Working Together to Safeguard Children 2015. This guideline appears to have a lot of duplication of information contained in other guidance for schools and colleges.	Thank you for your comment. There is a shorter version of the guideline (54 pages) which is the version NICE would expect practitioners to refer to. The longer version provides details of all the evidence reviewed those wishing to know more, and documents the GC discussion for transparency in relation to how the recommendations were made. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
Child Protection in Education - CAPE	Short	5	7	Add to the end of this bullet point **"and check your understanding of what the child has told you".**	Thank you for your comment. This has been added to recommendation 1.1.3.
Child Protection in Education - CAPE	Short	5	20	'Gillick competent' tends to be referred to with regards to medical law but we feel this sentence also needs to reflect and make reference to **Fraser guidelines**.	Thank you for your comment. It is NICE standard practice to refer to Gillick competency but not to the Fraser guidelines.
Child Protection in Education - CAPE	Short	5	22	Insert **"and record their disagreement"** after the word 'respect' on this line.	Thank you for your comment. This has been added to recommendation 1.1.6.
Child Protection in Education - CAPE	Short	5	26	We feel that the signing of records should be removed as this implies that a child is giving a statement when in fact this could simply be a disclosure.	Thank you for your comment. This was a suggestion from the Expert Reference Group of children and young people and has been included here as an illustration of one possible way to check that the young person has understood.
Child Protection in Education - CAPE	Short	5	43	Insert the following at the start of the sentence **"In line with your organisation's code of conduct, agree with the child……"**	Thank you for your comment. It is not clear which part of the document your comment relates to (there is no line 43 on page 5).
Child Protection in Education - CAPE	Short	6	17	Insert after participation…. **"whilst remaining child focused".**	Thank you for your comment. Recommendation 1.1.1 highlights the need to take a child-centred approach.
Child Protection in Education - CAPE	Short	7	10	Insert at start of sentence **"Casework supervision should support practitioners to think critically…..".**	Thank you for your comment. Recommendation 1.8.5 refers to supervision supporting reflective practice.
Child Protection in Education - CAPE	Short	8	6	Additional bullet point after line 6 to read **"they may face communication barriers because of a communication difficulty due to a disability, their age or English not being their first language".**	Thank you for your comment. Reference to communication difficulties and not speaking English fluently has been added

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					to recommendation 1.3.1.
Child Protection in Education- CAPE	Short	9	19	Where is the research to support this comment and who has validated the research?	Thank you for your comment. This recommendation was based on a good quality systematic review of 16 empirical studies (Hindley et al. 2015). This was critically appraised by the reviewing team according to NICE methods.
Child Protection in Education - CAPE	Short	10	6	It needs to be stressed that this box is not a tick list and that a child's individual context has to be considered. 'Body Rocking' may also be an indicator of autism, OCD and/or mental health issues and a precautionary note need to be added.	Thank you for your comment. We have added text in the introduction to this section highlighting that there may be other explanations for the behaviours described.
Child Protection in Education - CAPE	Short	11	21	Replace 'abuse and neglect' with **"an assessment of need"** as it would also include children who are young carers where abuse/neglect is not an issue.	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment. We recognise that this indicator could also include young carers. However, the focus of this guideline is on abuse and neglect.
Child Protection in Education - CAPE	Short	12	20	Remove the word **repeatedly** from this sentence as, on occasion, a standalone observation in the home can trigger a CP referral.	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment. The inclusion of 'repeatedly' is to distinguish this from occasional instances.
Child Protection in Education - CAPE	Short	13	20	Remove the phrase **'faltering growth'** as it does not address issues around obesity and morbid obesity. Perhaps consider instead **"Consider neglect if a child displays "growth outside the normal developmental range".**	Thank you for your comment. The evidence on obesity was considered as part of the development of NICE's guideline on child maltreatment. The guideline committee for this guideline thought the evidence was insufficiently strong to support a recommendation.
Child Protection in Education - CAPE	Short	14	24	Add further bullet point **"Parent cannot/will not use the child's communication mode".**	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment. We did not find any evidence in relation to parents using children's modes of communication.
Child Protection in Education - CAPE	Short	16	5	Remove the word **NHS** from the sentence as it does not have to be treatment exclusively provided by the NHS.	Thank you for your comment. Reference to NHS has been removed from recommendation 1.3.43 in recognition that this treatment could be sought from other providers.
Child Protection in Education - CAPE	Short	17	3	Needs to have additional information about children being trafficked within the UK – suggested re-wording of the sentence is as follows: **"Recognise that both girls and boys can be trafficked and that children and young people from the UK can be trafficked within the UK, nationally and internationally, as well as those from other countries".**	Thank you for your comment. Recommendation 1.3.46 has been amended as you suggest.
Child Protection in Education - CAPE	Short	17	11	Additional bullet point after line 11 about the need to ensure that family members or members of the family's community should not be used to translate key safeguarding messages and that this person should be an independent translator.	Thank you for your comment. Your point is intended to be conveyed in the bullet point in 1.3.47 which reads 'recognise that choosing an interpreter from the child's community may represent to them the community that has exploited them'. We have also amended the final bullet point to read 'independent interpreter'.
Child Protection in Education - CAPE	Short	22	1-3	After 'Children's social care' add **"within 24 hours".** At the end of line 3 add **"or initiate or review Early Help support".**	Thank you for your comment. This recommendation has been removed as it did not add to the information provided in Working Together 2015.
Child Protection in Education - CAPE	Short	22	17	There needs to be recognition that a safe place to live requires continued assessment/planning as those children subject to an assessment or CP plan may not always have a 'safe place to live'.	Thank you for your comment. Reference to a 'safe place to live' has been removed from recommendation 1.6.2 on the grounds that this is not within the remit of all practitioners to whom this recommendation is addressed.
Child Protection in Education - CAPE	Short	22	29	Remove the phrase **'when needed'** as there is an expectation that officers will speak independently to children when called out to Domestic Abuse incidents.	Thank you for your comment. Recommendation 1.6.3 has been

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					amended to cross reference to more detailed guidance provided in the NICE guideline on domestic violence and abuse.
Child Protection in Education - CAPE	Short	23	6	Add to the bullet point – **"specialist and *trained* interpreters".**	Thank you for your comment. Recommendation 1.6.4 has been amended to cross reference to more detailed guidance provided in Safeguarding children who may have been trafficked.
Child Protection in Education - CAPE	Short	23	27	Worth acknowledging that some parents may form a poor attachment if their child has a disability or special educational needs.	Thank you for your comment. It was not specifically mentioned in the studies reviewed whether children had disability or special education needs. We have therefore not referred to this group in the recommendation.
Child Protection in Education - CAPE	Short	24	3	Make reference within this bullet point about children with SEND.	Thank you for your comment. The studies we reviewed on which this recommendation is based did not make specific reference to children with SEND. We have therefore not made specific reference to this group in the recommendation.
Child Protection in Education - CAPE	Short	27	19	Why does this only apply to girls? – should this sentence not open with **"For children and young people (boys and girls)"?**	Thank you for your comment. The evidence on which this recommendation is based was a study undertaken with girls only. The guideline committee did not think it was appropriate to extrapolate this recommendation to boys. However, recommendations 1.7.17 to 1.7.19 are three possible options for children who have been sexually abused. The options in 1.7.17 and 1.7.18 would be available to boys also. We have included explanatory text at the beginning of this section as to why some recommendations are targeted at a specific population only.
Child Protection in Education - CAPE	Short	28	9	Early Help assessments should not be used for identified abuse and neglect cases especially those listed at lines 11-13 and there are also other kinds of abuse not listed here, for example, spiritual abuse.	Thank you for your comment. This recommendation (now 1.8.2) has been reworded to make clearer that this refers to 'concerns about abuse and neglect that do not meet the threshold for significant harm' rather than identified abuse and neglect. The term 'abuse and neglect' is intended to cover all forms of abuse and neglect.
Child Protection in Education - CAPE	Short	28	25	Many agencies are not co-located therefore there needs to be an insertion within this sentence about the need for **regular information sharing sessions across partner agencies.**	Thank you for your comment. In response to stakeholder feedback we have removed the recommendation regarding co-location.
Child Protection in Education - CAPE	Short	29	14	Additional bullet point stating that the **staff supervision session needs to be recorded.**	Thank you for your comment. We did not find evidence relating to this, and it is not required by Working Together 2015. We have therefore not added this to the recommendation.
Child Protection in Education - CAPE	Short	29	17-21	**Use the Working Together 2015 definitions.**	Thank you for your comment. The definition of 'abuse and neglect' is taken from Working Together 2015, as you suggest.
Child Protection in Education - CAPE	Short	30	16	Add **"benefit fraud"** to the list.	Thank you for your comment. This has been added to the definition of 'Child trafficking'
Child Protection in Education - CAPE	Short	30	18-19	Pre-birth to the day before your 18th birthday covers all children for the purpose of child protection and it becomes confusing to categorise 3 different age categories and how the document will refer to them. Can't you simply use the terminology **"children and young people"** throughout?	Thank you for your comment. We have used these age categories for consistency with the guideline on child maltreatment, on which some of our recommendations are based. For most recommendations we use the term 'children and young people'

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					unless the evidence suggested that something applied to a particular age group only.
Child Protection in Education - CAPE	Short	31	2	**Emotional Abuse – for consistency, use Working Together 2015 definition.**	Thank you for your comment. We have amended the definition of emotional abuse so it is consistent with Working Together 2015.
Child Protection in Education - CAPE	Short	31	15	Good opportunity to add the **mandatory reporting duty on individuals to report known cases of FGM to the police.**	Thank you for your comment. Recommendation 1.3.8 now refers to the Home Office guidance on mandatory reporting of female genital mutilation.
Child Protection in Education - CAPE	Short	31	24	**Add Fraser Guidelines**.	Thank you for your comment. It is NICE standard practice to refer to Gillick competency but not to the Fraser guidelines.
Child Protection in Education - CAPE	Short	32	10-13	**Neglect – for consistency, use the Working Together 2015 definition.**	Thank you for your comment. The definition of neglect has been amended to the Working Together 2015 definition.
Child Protection in Education - CAPE	Short	32/33	28-2	**Physical Abuse – for consistency, use the Working Together 2015 definition.**	Thank you for your comment. The definition of physical abuse has been amended to the Working Together 2015 definition.
Child Protection in Education - CAPE	Short	33	10-14	**Sexual Abuse – for consistency, use Working Together 2015 definition.**	Thank you for your comment. The definition of sexual abuse has been amended to the Working Together 2015 definition.
Child Protection in Education - CAPE	Short	33	14	**After 14 consider adding the current definition for Child Sexual Exploitation (2017) and a section on Honour Based Violence.**	Thank you for your comment. The definition of child sexual exploitation has been amended to the current statutory definition. A definition of honour-based abuse has been added to the glossary.
Child Protection in Education - CAPE	Short	34	9-10	Remove the sentence **"However, increasing training is likely to prove challenging for many organisations because of cuts in resources"** as this could be misconstrued as there are no resources so we don't require training.	Thank you for your comment. This sentence is intended to acknowledge the difficulty of providing training, given current resource constraints.
Child Protection in Education - CAPE	Short	37	10	Remove 'those taking the lead professional role' and insert **"those working with children and young people".**	Thank you for your comment. We have amended this text as you have suggested.
Child Protection in Education - CAPE	Short	40	6	Honour based violence appears here but not in the glossary & needs adding to the glossary.	Thank you for your comment. We have added a definition of honour-based abuse to the 'term used' section of the short guideline, and the glossary of the full guideline.
Child Protection in Education - CAPE	Short	40	13-22	There appears to be an emphasis on forced marriage within the Honour based violence recognition of risk and prevention section. **This does not reflect other forms of honour based violence such as false imprisonment, breast ironing, FGM, acid attacks and in some extreme cases the murder of the child/young person.**	Thank you for your comment. FGM is referred to in recommendations 1.3.8 and 1.8.3. The issue of breast ironing was not included in Working Together at the time our scope was developed (we used Working Together as the basis for our definition of abuse and neglect), and so was not included in the scope for the guideline.
Centre of expertise on child sexual abuse	Full	4	21	Whilst we understand the scope of the guidelines (below): "The guideline does not cover interventions provided to people who are suspected or known to abuse children or young people of whom they are not the parent, step-parent, partner of a parent, family member or carer. Abuse perpetrated by this group will be in scope, but interventions for this group will not." However, grooming by young people who are victims of CSE of other young people is a grey area which challenges practitioners, managers and commissioners. It is particularly salient to interventions where young people as victims are placed together with other young people at risk. We would recommend that guidance for practice needs to emphasise the complexity of work with CSE victims who are drawn into grooming of other victims, and the importance of supervision and specialist training for workers to formulate responses both to potential victims and with the victim-perpetrator. This would be particularly relevant to frontline workers in residential settings. It may be that some of this guidance links to your recent guidance around working with children and young people where there is harmful sexual behaviour, although a specific focus on CSE would be important. We imagine you will already have received advice alerting you to the new Guidance on CSE: https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners. If not it	Thank you for your comment. We found little evidence that met our criteria relating to grooming of young people by other young people. This was also noted in the NICE guideline on harmful sexual behaviour among children and young people. We have updated the definition of CSE used in the guideline to match the new statutory definition.

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				would be an important resource to link to.	
Centre of expertise on child sexual abuse	Full	General	General	We would recommend a specific recognition of the importance of involving parents where appropriate in situations involving CSE. This might take a similar form to the updated advice around CSE released for Working Together. The involvement in parents is particularly important for CSE, and may be difficult to develop in organisational systems oriented to addressing neglect and abuse. A large part of the guidance document is heavily oriented to a framework which views parents in terms of potential risks and failure to protect, and whilst this is understandable, it can lead to challenges for practitioners faced with situations involving CSE. In relation parents you may wish to refer to the body of work done by Research in Practice on adolescent risk more widely, eg: https://www.rip.org.uk/resources/publications/evidence-scopes/that-difficult-age-developing-a-more-effective-response-to-risks-in-adolescence-evidence-scope-2015	Thank you for your comment. Recommendations 1.1.10 and 1.1.11 provide general guidance in relation to building good working relationships with parents and carers. 'That difficult age' (Hanson and Holmes 2014) was identified during the update searches, and screened on title and abstract, but was not relevant to any of the review questions being updated (see Appendix A for more information).
Centre of expertise on child sexual abuse	Full	13 & 33		This appears to be a key area of need for CSE, and something we note appeared in workshop discussions during the consultation process. The recommendation in 1.1.13 and recommendations in 1.7 address issues of professional cooperation but focus on professional independence and coordination. These might be improved by guidance around professionals also learning from each other, particularly through developing a shared learning and reflection strategy. This is increasingly relevant in multi-agency safeguarding responses where professionals need a deeper understanding of other perspectives and can benefit from access to joint training and professional development.	Thank you for your comment. We did not review any evidence in relation to learning and reflection strategies. We have made reference at the beginning of this section to Working Together 2015.
Cheshire East Council	Short/full/appendix	General	general	It is difficult to see what added value this will have for front line practitioners and managers in the Local authority, there is already extensive statutory guidance for staff who have aa direct role in the safeguarding of children and young people (WTSC 2015) and multi-agency procedures, protocols and practice guidance for all staff. This is all supported through single and multi-agency training. Whilst there is much in this that is 'common sense' and would be helpful for some workers, it does not cover the needs for the range identified at the outset, given the scope, size and complexity of the subject. It might be that if reorganised on the basis of the level of practitioner, it would be easier for staff to access what would be relevant to them in their role. Also feedback for the use of WTSC has identified that flow charts are a quick win to influence practice. However if the intention is to provide guidance with a research base for informing intervention there is insufficient of this and it is not set out in a way that enables those practitioners who would find it useful to access it easily, particularly as many of these are already available. These cover an increasing number of 'specialist' areas as types of abuse become better understood and the complexity of response demands greater knowledge and skills development. There are gaps within this guidance, for example, peer relationship abuse, risk assessment and management of perpetrators/ people who harm. It's not clear how joined up this guidance is with the reforms that will take place following the publication of the Children and Social Work Bill and its implications for professionals working with families where abuse is an issue. Appendix 1 Specific comments on the NICE guideline: short version The draft doesn't reflect the need for easy translation of guidance into practice. The section on telling others about abuse and neglect (1.2.1) does not really recognise the importance of trusting relationships in the disclosure of abuse, particularly sexual abuse, by children and young people. This is critical for practitioners to understand so they stay with the child, move at their pace but never lose sight of the central role they have in safeguarding the child. Some of the behavioural indicators of neglect (1.2.25-27) seem overly simplistic and leave little room for the consideration of factors outside of the parent/carers immediate control e.g. poor quality housing, insecure employment, benefit sanctions etc. It is noted in passing that professionals may find it difficult to distinguish between neglect and poverty. In the assessment section (1.3), there is limited reference to the existing assessment guidance for social workers and other professionals, to assessment tools, planning interventions or reviewing impact. The characteristics of abuse need to be placed in an analytical framework and specific risk factors within that evaluated. Responses and support for children and young people who experience abuse (1.5.3), is problematic. It's not clear who the actions are aimed at? Why is the domestic violence section only addressed at the police (1.5.4)? (1.5.5) Why are the suggested responses listed here e.g. provide safe accommodation, only about child trafficking? It is unclear why the therapeutic interventions for children, young people and families after abuse and neglect (1.6) deals with children living in the family home or with foster carers but not in residential care settings, including children's homes and supported lodgings. These are often our most vulnerable children and young people and this needs to be identified and recognised.	Thank you for your comment. This guideline aims to add to existing statutory guidance by providing recommendations based on a systematic review of the research evidence. There were a number of areas of the scope for which we were unable to identify robust evidence (for example, online grooming and abuse), and so recommendations were not made. Where there were gaps in the evidence base, the committee has made recommendations for further research. Following consultation feedback, we have aimed to make it clearer which sections of the guideline are relevant to which practitioners. However, the view of the committee was that producing individual guides for particular groups of practitioners would not support effective multi-agency working. With regard to flowcharts, a 'care pathway' flow diagram to support the use of the guideline will be produced by NICE. We have made a number of changes to the guideline to reflect the Children and Social Work Act, particularly with regard to terminology around local structures such as former Local Safeguarding Children Boards. In relation to your specific comments on the short version: Telling others about abuse and neglect – recommendations 1.1.1 to 1.1.9 outline a number of features of how to work with children and young people to build up trust. Recommendations 1.3.1 to 1.3.8 also refer to factors that can help or hinder children and young people to disclose abuse and neglect, and how practitioners should work in those situations.

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				It is unclear why the guidelines refer only to girls who have been sexually abused and who are showing signs of emotional or behavioural disturbance (1.6.17). We are aware that young men and boys are also victims (recent national disclosure of abuse by football coaches evidence this). There are often additional hurdles for males to overcome to disclose and it is critical that guidance seeks to remove these barriers not add to them. . The 'planning and delivery' section (1.7.3) identifies child sexual exploitation (CSE), female genital mutilation (FGM), forced marriage and child trafficking, as forms of abuse less well identified. This is outdated and misleading, these are well known and eg online grooming and exploitation and radicalisation. Terms used in this guidance (page 29 onwards) - the Home Office published an updated definition of CSE earlier this year, it would be helpful if the final guideline reflected this to avoid any confusion. Similarly, reporting of suspected FGM cases is now mandatory, again, it would be helpful if this was reflected here. The context section (page 36 onwards) seems to omit reference to several key changes in the design and delivery of children's services. Local safeguarding children boards (LSCBs) are referenced as are serious case reviews (SCRs), yet under the CSWB, which is expected to receive royal assent in the coming weeks, neither will exist in the future. Further, the CSWB will put sex and relationships education on a statutory footing for the first time. Equipping children and young people with knowledge and courage to recognise the signs of abuse should be central to prevention. The planning and delivery of services is dealt with in Working Together and sits within the remit of multi-agency safeguarding arrangements (currently LSCBs). The recommendations for further research are helpful and would sit well with a section which considers the current weaknesses and limitations of the evidence	Behavioural indicators of neglect - We have now added further detail at the beginning of the section on alerting features regarding the actions that practitioners should take if they observe the alerting features described. Recommendation 1.2.2 was drafted following consultation feedback and refers to environmental vulnerability factors for abuse and neglect, including poverty poor housing. With regard to assessment, we have now made clearer that practitioners should refer to guidance on early help and statutory assessment in Chapter 1 of Working together to safeguard children as well as local protocols for assessment. As such, we would expect practitioners to use the Assessment Framework as their analytical framework, in line with statutory guidance. We searched for evidence on assessment tools, but did not find any studies which met our criteria. This was not identified as a priority area for expert witnesses by the guideline committee. Domestic abuse – these recommendations (now 1.6.3) have been amended to cross-refer to the more detailed guidance provided by the NICE guideline on domestic violence and abuse. Residential care - There is an existing NICE guideline on services to support the health and wellbeing of looked after children, which includes recommendations relating to provision of residential care. Our recommendations therefore do not cover therapeutic residential placements. Our literature search focused on interventions provided directly to children and young people, or to them via their caregiver. Interventions provided directly to children and young people (for example trauma-focused CBT) could still be provided to children and young people in residential settings. For therapeutic interventions following sexual abuse, the guideline suggests three possible interventions, of which two have been shown to be effective for both girls and boys. The intervention recommended for girls only (now recommendation 1.7.19) is because the underpinning research had been conducted with girls only, and the committee did not think it was appropriate to extrapolate this to boys also. Planning and delivery – in response to your and others' feedback we have removed the term 'less well-recognised' from this recommendation (now 1.83) and

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					also added in reference, honour-based abuse, serious youth violence and gang-related abuse. We have also cross-referenced the relevant content in Working Together 2015. The committee also made a research recommendation in relation to online facilitated abuse, including online grooming. We have updated the definition of CSE to the new Home Office version. The context section has been updated with recent legislation and reference to LSCBs and SCRs has been removed. With regard to discussion of weaknesses and limitations of the evidence, this is now referenced briefly in the introduction, but is discussed in detail in Section 3 of the full guideline.
The Children's Society	Full	General	General	The guideline is a comprehensive and welcome contribution to improving professional responses to abuse and neglect. However, the brief of 'abuse and neglect' is a very wide one, and, given that the guideline is based primarily on published research, it tends to reflect the current biases and gaps in the field. For example, in some sections, 'maltreatment' is treated as a uniform concept regardless of the type of abuse or neglect which a young person has experienced (because the few longitudinal studies published often homogenise 'abuse and neglect'). Similarly many studies fail to discriminate between experiences at different ages and to allow for the differential impact of age and development (see further comments below). Studies and papers are beginning to emerge which show the importance of differentiation by age and maltreatment type – e.g. the Rochester Youth Development Study (see below) – but there is, as yet, only piecemeal robust evidence to cite. We would recommend that the guidance reflects on that challenge at the outset of the document and / or explains a strong caveat about the limited scope of the available research?	*Await NICE decision about format.*
The Children's Society	Full	General	General	A major gap in the evidence base relates to neglect, particularly neglect during adolescence (age 11-17). The Children's Society, in partnership with academics from the University of York (Gwyther Rees and Mike Stein) is undertaking a new programme of research on adolescent neglect. This builds on earlier collaborative research exploring the international literature, the perspectives of young people and multi-agency staff and the implications for policy and practice (Stein et al, 2009; Rees et al, 2011; Hicks and Stein, 2010; 2015). The first study, which used an innovative method to measure adolescent neglect, was published in November 2016: https://www.childrenssociety.org.uk/sites/default/files/troubled-teens-full-report-final.pdf . A report on defining, identifying, assessing and working with adolescent neglect, commissioned by the Luton Safeguarding Children Board, will be published in May 2017. Other new studies in the field include, for example, Lalayants and Prince (2016) – which shows that neglect in adolescence is a significant predictor of substance misuse (whereas other forms of maltreatment were not).	Thank you for your comment. Recommendations 1.3.24 to 1.3.28 and 1.3.38 to 1.3.44 refer to recognition of neglect, recommendations 1.3.33 to 1.3.34 refer to recognition of emotional neglect. Recommendation 1.3.16 highlights substance misuse as an alerting feature for abuse and neglect. (The evidence we reviewed suggested that this association held for other forms of abuse as well as neglect.) Recommendations 1.7.1 to 1.7.16 refer to therapeutic interventions following neglect. Thank you for suggesting studies dealing with the topic of neglect and adolescence. It is interesting to hear about the project that The Children's Society and University of York are undertaking, although work that is not yet published would not be eligible form inclusion in the guideline. The following references you have provided were screened during development: Stein et al (2009) was excluded as the study population were not specifically described as having experienced abuse or neglect.

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					Rees (2011) was excluded because it was not an empirical study, as was the article by Hicks and Stein (2010). Hicks and Stein (2015) was also outwith the protocols for inclusion, as it was a narrative review of the literature, rather than a systematic review or a meta analysis. The Lalayants and Prince (2016) study you suggest is unfortunately outside the date range for our searches for this review question – see Appendix A for further detail.
The Children's Society	Full	General	General	An important study that does not seem to be referenced in the guideline is the Rochester Youth Development Study a multigenerational longitudinal project which began in 1988 with a sample of 1000 adolescents (and their parents) from a deprived borough of New York, and has followed them until they were 31 years of age, with little attrition. Regular interviews and the analysis of a range of official data (on health, offending, etc.) have allowed the researchers to conduct analyses of a variety of aspects of the issues that can arise as young people grow and mature – particularly in relation to maltreatment. A number of research articles have been published with significant findings in relation to the chronology of maltreatment, its impact and the differential effects of maltreatment types (e.g. Thornberry, Ireland and Smith, 2001; Smith, Ireland and Thornberry, 2005; Thornberry et al, 2014)	Thank you for your comment, and for the studies you have suggested for inclusion in the Guideline. In order to use the most recent data, the review protocols specified a cut-off date of 2004 for inclusion. A date cut-off is used to limit the volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal framework for how social services and other agencies deal with issues relating to children. Therefore the Thornberry, Ireland and Smith (2001) study could not have been considered. The other 2 studies you name were both considered for inclusion for RQ3, but did not meet the study design criteria (systematic reviews and meta-analyses only).
The Children's Society	Full / short	General	General	It may be helpful to include somewhere in the guideline a note to describe the link between adolescents' own behaviours and how they are treated by parents. Longitudinal studies have shown, for example, that problematic behaviour in adolescent girls led to reduced support and control by parents over time (Huh, 2006), and that young people who reported a negative relationship with parents were more likely to be aggressive or delinquent in early adolescence, to continue with these behaviours and to then report even worse perceptions of relationships with parents at a later point (Buist et al, 2004). Practitioners may need to be aware of this dynamic operating in parent-adolescent relationships, something which can contribute to the development of neglect.	Thank you for your comment. Recommendation 1.4.4 on assessment refers to considering quality of relationships as part of the assessment process. The studies you suggest were identified by our searches but were excluded at title and abstract screening based on population.
The Children's Society	Short	7	26	Children and young people telling others about abuse and neglect may include the following additional points: • Adolescents' own assessments of the occurrence and nature of neglect (and abuse) may be different from those of professionals and may offer a more accurate predictor of outcomes (Farmer and Lutman, 2010). • Adolescents who are being neglected may feel protective of their parent / caregiver, despite recognising that they are not being adequately supported – e.g. in families where there are other difficulties (perhaps where a sibling, or parent, has a significant health need; where a parent suffers from episodic mental ill health). (Wayman, Raws and Leadbitter, 2016; Rees et al, 2011). Critically, adolescents define 'neglect' in broader terms than the categories used for child protection purposes, and this has important implications for professional practice (and policy development). To strengthen responses a priority should always be given to seeking the views of young people about their experiences of neglect and the implications for working with them (Hicks and Stein 2015).	Thank you for your comment. The committee recognised that children and young people's views and understanding of their own situation are of crucial importance. Recommendations 1.1.1, 1.1.3, 1.1.4, 1.4.1 and 1.4.2 aim to highlight the importance of working in a child-centred way and hearing the child's voice. Recommendation 1.3.1 also makes reference to the fact that children or young people may be attached to the person who is abusing them. The studies you have suggested were all identified in the searches for the guideline, but were excluded for the following reasons: • Farmer and Lutman (2010) excluded based on title and abstract as did not relate to any of the review questions • Hicks and Stein (2015) excluded on evidence type (narrative review) • Rees et al. (2011) excluded on study design (not empirical

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					study). • Wayman et al. (2016) excluded on study design (not empirical study).
The Children's Society	Short	8	24	Additional point on child risk factors for abuse and neglect □ Recognise that boys can be more likely to be neglected with regard to supervision and monitoring by their parents / caregivers – potentially making them vulnerable to abuse outside the home (Raws, 2016).	Thank you for your comment. Recommendation 1.2.6 now encourages practitioners to consider the impact of gender on children's risk of abuse and neglect.
The Children's Society	Short	9	3?	'Family risk factors' – *not covered in the guideline.* Our research suggests that, particularly for older children, times of transition and change within a family can be a context for neglect to arise. Changes in family composition (parental separation, the introduction of a step parent / step siblings to a household), moving to a new area, bereavement or redundancy, can all undermine parenting capacity and lead to young people being neglected (e.g. Safe on the Streets Research Team, 1999; Rees et al, 2011). In addition, when young people are becoming more independent parents may find this difficult and opt out, and the issue of young people being forced out from the family home can arise. This is a clear example of neglect but one that is an act of 'commission' rather than 'omission' (parents *not* providing care and support which is the way neglect is usually defined). This brings an added complexity to how neglect is understood and addressed for this older age-group (Rees et al, 2011).	Thank you for your comment. Recommendations 1.2.3 to 1.2.5 refer to family vulnerability factors. The recommendations reflect the evidence reviewed by the guideline committee. The review protocols specified a cut-off date of 2004 for inclusion. A date cut-off is used to limit the volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal framework for how social services and other agencies deal with issues relating to children. This means that the Safer in the Streets research team's publication was not eligible for inclusion. Rees et al (2011) was screened and excluded on evidence type (not empirical study).
The Children's Society	Short	11	9	*(Additional behaviour for 'considering neglect')* Frequently missing school (Raws, 2016)	Thank you for your comment. This indicator is covered in the NICE clinical guideline on child maltreatment.
The Children's Society	Short	12	16	The 'behavioural indicators of child neglect' are all linked solely to physical neglect – and some are not behavioural ('being smelly, having head lice'). They also relate primarily to indicators that would more likely be seen among young children. Although the research is limited, adolescents may show behavioural indicators – for different forms of neglect – in different ways. For example, where they lack adequate supervision they may be involved in risky behaviours away from home / late into the evening (e.g. substance misuse – Lalayants and Prince, 2016), or they may miss school frequently. Or where they are emotionally neglected they may have difficulties with sleeping, with mood, or attention at school (Raws, 2016; Rees et al, 2011).	Thank you for your comment. Recommendation 1.3.16 relates to behaviour indicators of abuse and neglect that can relate to older children, including substance misuse, self-harm, eating disorders, suicidal behaviours and bullying. These indicators reflect the evidence base reviewed by the guideline committee.
The Children's Society	Short	14	1	*Additional point re. indicators* – these were highlighted by young people themselves in research on neglect (Rees et al, 2011): □ Consider physical neglect if a young person is obese – i.e. parents may not be paying adequate attention to a young person's diet or level of exercise. □ Consider neglect if an older adolescent is not developing skills for independence – i.e. parents may not be fulfilling the role of supporting a young person towards adulthood. □ Consider neglect if a parent / carer is often not aware (or unconcerned about) a young person's location, activities, associations outside home.	The evidence base on obesity was considered as part of the development of NICE's guideline on child maltreatment. The guideline committee for this guideline thought the evidence was insufficiently strong to support a recommendation. Recommendation 1.3.17 refers to children and young people who have run away from home or care. We did not find evidence relating to skills for independence. Rees et al (2011) was screened on title and abstract but excluded based on study design (not empirical study).
The Children's Society	Short	14	29	Although there may be particular reasons to consider emotional neglect in relation to unavailability of parent or carer towards an infant, this is also important in relation to adolescents. Our research showed that emotional neglect of 14-15 year olds had the strongest associations with low levels of subjective well-being for them, suggesting that emotional support remains vital to older young people too – even though parents may not be aware of, or prioritise, this form of care. (Raws, 2016)	Thank you for your comment. This recommendation is adopted from the NICE guideline on child maltreatment and is based on the evidence reviewed for this guideline.

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The Children's Society	Short	15	11	Point 1.2.38 needs qualification with regard to adolescent, i.e. that parents will have to judge when to grant young people autonomy and decision-making as they grow older, but that there are situations where parents may absolve themselves of keeping rules / preserving sanctions which are indicative of supervisory neglect (and a lack of 'authoritative parenting – the 'ideal' model – MacCoby and Martin, 1983).	Thank you for your comment. We have defined 'child' in the guideline as being from 1 to 13 years, and 'young person' as 13 to 17 years. This recommendation therefore refers to younger children.
The Children's Society	Short	15	18	Point 1.2.40. This could include an older young person / adolescent who themselves is being neglect [as demonstrated by a parental expectation that they can be given caring responsibilities for a younger sibling(s)]	Thank you for your comment. We agree that this would be covered by the current wording.
The Children's Society	Short	15	21	Providing access to medical care or treatment*(additional point)* □ Consider neglect if a teenager has a baby (neglect in adolescence is the strongest predictor of teen births – Noll, 2013).	Thank you for your comment. Pregnancy is mentioned in the NICE guideline on child maltreatment. The study by Noll was considered for RQ3, but in the end was not selected for inclusion as it was not a systematic review, and these were being used as the sole source of data for this RQ in order to draw data from as wide a range of sources as possible.
Colin Green Consulting Ltd.	Full version	General	general	Scope: the guideline says it is aimed at "all practitioners". Given its scope, size and complexity this is far too broad a group of practitioners. The different roles in children's service require different approaches to guidelines and presentation of what is considered good practice. Previous guidance, including on training, has recognised the different needs within the children's workforce depending on the level of contact with children and the significance within the role of work with children who have been abused and neglected. For example, advice on recognition is relevant to all practitioners while advice on assessment is only relevant to those with more specialist roles in assessing children where abuse or neglect are or may be an issue. The guideline would be much more useful if organised to reflect these differences.	Thank you for your comment. Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action.
Colin Green Consulting Ltd.	Full Version	General	general	Method: The method adopted of identifying questions, undertaking a major literature review, identifying what the evidence says in relation to the various questions and then using this to develop the guideline seems logical. However, what it has produced is a document that is not well grounded in the existing guidance and sources of good practice advice. These are not well referenced in the guideline. It appears that the NICE methodology has been applied rigidly without considering whether it will produce a useable and useful product in this area of practice or the merits of building on what has gone before or without adequate consideration of implementation in this area of service.	Thank you for your comment. The remit of NICE is to develop evidence-based guidance, based on a systematic and transparent review of the evidence, and this is what distinguishes NICE guidance from many other types of guidance As you note, this guideline has been developed using the methods set out in the NICE manual, which does focus on using empirical research as a source of data. However, we were cognisant of the nature of the social care evidence base and aimed to capture relevant evidence, whilst operating within the NICE methodology. These included: a) Developing a series of review questions relating to 'aspects of professional practice'. These questions sought to explore professional practices which did not fit easily within the concept of 'an intervention'. b) Developing a review question about organisational factors supporting effective practice. c) Inclusion of review questions on the views and experiences of children and young people, parents and practitioners. We have now added explanatory text at the beginning of the guideline about how it was developed, and the sources of evidence used. It was the view of the committee that this was made this guideline different from, and additional to, other existing sources of guidance in this

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					area.
Colin Green Consulting Ltd.	Full version	General	general	The limitations of the evidence are not well discussed in the guideline and rather than using experts more extensively too much reliance is placed on the research studies. Many of these are poor or of limited relevance to a UK context.	Thank you for your comment. Critical appraisal of all studies is reported in full in Appendix B to the guideline. The guideline committee considered carefully the applicability of US evidence to the UK context and were of the view that this evidence was applicable to a UK context, particularly given that this was the highest quality evidence. Experts were involved in a number of ways in the guideline, including use of a guideline committee of practitioners, academics and service users; expert by experience input from service users on the guideline committee and an expert reference group of children and young people; testimony from four expert witnesses and views gained through consultation.
Colin Green Consulting Ltd.	Full Version	General	general	More specifically: 1. There is too little reference to what previous work has been done to develop guidelines or guidance i.e. there is little building on what practitioners may already be familiar with. The various versions of Working Together but especially 2010 cover a great deal of what is considered good practice in working with children who are abused and neglected including on identification, values, principles of working with children and families and much else. 2. The guideline uses a great deal of research from the USA and other areas, much of which is not of high quality, without recognising that even where the research is good there are very significant issues of transferability to the UK context. This also applies to UK research where what has worked in one place has not transferred well into another context. There appears to be no discussion of these very important implementation issues. 3. The guideline does not address the deficit in the research by a wider use of expert opinion – this is limited in most areas of the guideline which is a missed opportunity. 4. Makes almost no effort to consider how the guideline might be used in practice. For example, in section 1.2 on recognising abuse and neglect there are long lists of "symptoms" without any development of how these might be used including the impact of combinations of possible indicators of abuse. There was an intention, described in early meetings of the guideline development group, to involve Research in Practice in considering implementation issues but this has no visibility in the final guideline which is almost unusable in its current form.	Thank you for your comment. The guideline has been produced in line with the NICE guidelines manual. A key principle of the NICE process is that guidance is based on the best available evidence of what works. The basis of NICE guidance is therefore typically the empirical research evidence base. The review protocol did allow for inclusion of evidence from other countires, including the US. This was agreed with the guideline committee at the start of the process. Due to the wealth of evidence found in our searches, our inclusion criteria for questions on effective interventions were amended to focus on the highest quality research designs only (randomised and quasi-randomised control trials). The included studies are therefore represent the highest quality evidence available in terms of rigour of design. The majority of the highest quality evidence did not come from the UK, and we have drafted research recommendations in response to this. The committee made use of expert opinion in relation to forced marriage, female genital mutilation, child sexual exploitation and child trafficking. These areas were prioritised in discussion with the guideline committee. Other areas of the scope (for example, assessment) were not prioritised as we found some empirical evidence in these areas in relation to aspects of professional practice and ways of working. With regard to the section on Recognition, the aim of this section is to provide information on 'alerting features' to prompt further action. The evidence base did not support weighting of particular features. Recommendation 1.2.1 highlights the issue of co-occurring vulnerability factors. Research in Practice are a partner in the

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					NCCSC and, as such, were involved in scoping and the development of the guideline.
Colin Green Consulting Ltd.	Short version	1.2.9		In section 1.2.9 the list of parental risk factors is so broad and generalised as to be of very little value.	Thank you for your comment. These general vulnerability factors are intended to be considered with the more specific alerting features described in Section 1.3. Additional text has been added to the introduction to Section 1.2 to clarify this.
Colin Green Consulting Ltd.	Short Version	1.3		1. There is very little on assessment, analysis, planning interventions or reviewing impact. There may have been little evidence found from the literature search in these areas but this is where use of experts could have contributed to putting forward best practice advice. 2. In the assessment section, there is no or very limited reference to the existing assessment guidance for social workers or indeed guidance for other professionals. There is very little reference to assessment tools which is surprising. Possibly the evaluations were too weak. However, reference to this would have been helpful or use of expert opinion if no research of sufficient quality was available. 3. Almost nothing on analysis and planning. The lists of characteristics are almost useless without consideration of how practitioners are to use them in an analytical framework. Why is this not considered?	Thank you for your comment. We have now made clearer that practitioners should refer to guidance on early help and statutory assessment in Chapter 1 of Working together to safeguard children as well as local protocols for assessment. As such, we would expect practitioners to use the Assessment Framework as their analytical framework, in line with statutory guidance. We searched for evidence on assessment tools, but did not find any studies which met our criteria. This was not identified as a priority area for expert witnesses by the guideline committee. We also searched for evidence about aspects of professional practice in relation to assessment. Much of the evidence related to gathering information – there was little empirical evidence about best practice in relation to analysis and planning. The committee therefore felt they were unable to add to the statutory guidance in this area.
Colin Green Consulting Ltd.	Short version	1.4.1		Early Help. 1.4.1 refers to home visiting programmes without naming specific programmes. Without the specifics, this is not useful. The section on parenting does name specific programmes which is more helpful.	Thank you for your comment. We have now provided an example of one of the effective home visiting programmes for which we found evidence.
Colin Green Consulting Ltd.	Short version	1.4.9		Early Help. 1.4.9 says "Consider a planned activities training programme, with or without mobile phone support, for vulnerable mothers of preschool children." This is an example of meaningless advice. Who is this aimed at, what is the programme, does the content matter etc.?	Thank you for your comment. The wording of this recommendation (now 1.5.10) has been amended to make the content of the programme clearer.
Colin Green Consulting Ltd.	Short version	1.5.3, 1.5.4, 1.5.5		Response and support. 1.5.3 Who is this addressed to? 1.5.4 Why is this only addressed to the Police? 1.5.5 Why is this only about child trafficking. More examples of disembodied advice in the guideline that it is hard to see being of any value to practitioners	Thank you for your comment. The wording of this recommendation (now 1.6.2) has been amended to make it clearer that this recommendation is aimed at all practitioners supporting children and young people who have been assessed as being 'in need' or at risk of significant harm in relation to abuse or neglect, with leadership and coordination by the social worker. Recommendation 1.5.4 has been removed and instead recommendation 1.6.3 cross references to the NICE guideline on domestic violence and abuse. Recommendation 1.5.5 has been replaced by a cross-reference to the guidance in Safeguarding children who may have been trafficked. With regard to your general point, Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action.

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Colin Green Consulting Ltd.	Short Version	1.6.4		Therapeutic Interventions. 1.6.4 Who are these recommendations addressed to? Which attachment based interventions? 1.6.6 Where is parent child psychotherapy available? Has any NHS commissioner ever commissioned this in England? 1.6.8 more therapy suggestions where it is unclear who they are addressed to. It may be that the guideline saw it as out of scope to consider whether any of these therapies are available in the UK or whether anyone would pay for them. However, from the practitioner perspective or a commissioner perspective some discussion of availability, cost etc. would be very relevant. There are many recommendations in the therapeutic interventions section of this kind. These recommendations have no context and are too brief to be of any use for those who do want more information.	Thank you for your comment. We have added text to the beginning of Section 1.7 to make clearer that these recommendations are aimed at strategic commissioners of services for children and young people who have been abused or neglected; social workers and others coordinating support for children and young people, to help them decide what services to refer children and young people to; and child and adolescent mental health practitioners (psychologists, psychotherapists, psychiatrists), practitioners in specialist family intervention teams (for example social workers) and voluntary sector agencies. We have also added examples of the attachment-based interventions identified as effective via our evidence review. With regard to availability and resource impact in general, this was considered by the guideline committee, including consideration of economic evaluation and modelling data where available. The committee also discussed the extent to which these interventions were available, drawing on expertise from social care and CAMHS within the group. Where cost-effectiveness evidence or economic modelling was not available, the committee made some 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence. 'Consider' means that practitioners should think about providing the intervention, rather than that they must offer it. The committee also considered the availability of therapeutic interventions. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Given all these considerations, the recommendations were felt by the guideline committee to be aspirational but achievable. With regard to parent-child psychotherapy specifically it was the view of the committee that this intervention was available through CAMHS.
Colin Green Consulting Ltd.	Short version	1.7		Planning and delivering services. Why is this included at all given it is Working Together and within the remit of LSCBs?	Thank you for your comment. This guideline has aimed to add further detail to support implementation of Working Together 2015 by highlighting areas of practice which have been shown by empirical evidence of being as of particular importance, or not always working well in practice. The recommendations in this section highlight particular aspects of

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					planning and delivery that were identified in the empirical evidence base.
Colin Green Consulting Ltd.	Short version	Section 12 page 33		Putting the guideline into practice. It is hard to see that any thought has been given to how this guideline will be put into practice. There is no sense of an understanding of the context for use of the guideline. Who is it addressed to with an expectation they will put it into practice? It seems that a NICE formula for implementation has been applied without thought that this is addressed to a different context than most NICE guidance. As noted above there is early reference to working with Research in Practice but no evidence that this has happened or that any other approach to implementation has been given serious consideration.	Thank you for your comment. Please be assured that implementation issues have been considered throughout development of the guideline, including through stakeholder consultation on the scope; involvement of Research in Practice in the Collaborating Centre team; and specific slots looking at implementation within Guideline Committee meetings. Stakeholder comments on the draft guideline have also provided significant input relating to implementation, and the guideline has been amended accordingly.
Colin Green Consulting Ltd.	Short version	Section 15 page 39		Recommendations for further research. These are helpful and would sit well within a section which considers the current weaknesses and limitations of the evidence.	Thank you for your comment. In response to your feedback, we have given an overview of the main sources of evidence and some key limitations in the introduction to the guideline.
Colin Green Consulting Ltd.	Short and long version	General		Other comments 1. To have impact the guidance needs: a. Much better contextualisation of the recommendations including how they relate to existing guidance, the current resource constraints on all agencies working with children and the limitations of the research base. b. Greater clarity about who the guideline is for and to reorganise it to reflect the roles in children's services and their level of engagement in recognition and acting on abuse and neglect. c. The guideline written with consideration of how practitioners might use it. d. Much more focus on the centrality of relationships in work with children and families e. Better use of experts to inform the guideline and make more nuanced judgments about how the evidence is used f. More weight to UK interventions which might be accessible to practitioners and commissioners who read the guideline 2. Overall it seems that NICE has applied its method to this area without adequate regard as to whether this method will produce a useful result. I note there was some practitioner involvement in the consultative group for the guideline but the style of the guideline made me wonder what influence they had. There seems to have been no input from ADCS or senior local authority staff or from the Police or the voluntary sector or Research in Practice with their expertise in helping practitioners use research or academics with a strong reputation for a focus on social work practice or who have conducted work such as the biennial reviews of SCRs. This has been a major missed opportunity to produce something useful for the sector.	Thank you for your comment. In response to your feedback we have: - Developed a more detailed introductory section, including the relationship of this guidance to existing guidance, the current practice context, and the evidence base for the guideline. - Provided more detail about the audience for the guideline as a whole, and for specific sections within it. With regard to application of the NICE methodology, we were cognisant of the nature of the social care evidence base and aimed to capture relevant evidence, whilst operating within the NICE methodology. This included: a) Developing a series of review questions relating to 'aspects of professional practice'. These questions sought to explore professional practices which did not fit easily within the concept of 'an intervention'. b) Developing a review question about organisational factors supporting effective practice. c) Inclusion of review questions on the views and experiences of children and young people, parents and practitioners. Research in Practice are a partner in the NCCSC and, as such, were involved in scoping and the development of the guideline. The guideline committee also included several local authority managers of children's services, representatives from the voluntary sector and several academics working in the field of children's social care. A representative from the police was invited, but was unable to attend. Please see the full guideline for guideline committee membership.

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					With regard to relationship-based practice, recommendations 1.1.1 to 1.1.11 set out how to build good working relationships with children, young people and families. These are based on research evidence input from a children and young people's Expert Reference Group. Recommendations 1.5.1, 1.5.2, 1.5.3, 1.7.1, 1.7.2 and 1.7.3 also emphasise the importance of engaging in dialogue with children, young people and families regarding any support and interventions, and offering any interventions based on clear assessment.
Colin Green Consulting Ltd.	Short and long version			Final comment. A great deal of work has gone into producing this guideline. The literature review is very extensive. It is therefore with regret that I consider most of this effort has been wasted. In its current form, it is hard to see the guideline having any practical use or influence on practice.	Thank you for your comment. We have taken your feedback, and those of other stakeholders, on board and are working to articulate the value of the guideline more clearly, and make it easier to use.
Department for Education	Full	General	general	It is unclear who the audience for this guidance is and what status it has against other statutory guidance for inter-agency work. Particularly, how does this guidance fit with 'Working Together' and will it complement or confuse? As it stands, it has the potential to confuse. This is not statutory guidance from the government and so it might be more impactful if it could be clearer on the principles needed for effective practice and how this has been evidenced. The document as it stands does not bring and add wisdom to the debate. It is rather long and misses the point, as it is rather disparate in the way it has been put together. A shorter, more focussed document, which was clear on its role and purpose, would add more value.	Thank you for your comment. We have amended the introductory sections of the guideline to make clearer how it fits with Working Together 2015 and other statutory guidance, and the principles by which it has been developed. We have also made clearer the intended audience in the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, There is a shorter version of the guideline (54 pages) which is the version NICE would expect practitioners to refer to. The longer version provides details of all the evidence reviewed for those wishing to know more. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
Department for Education	Full	General	general	There is a fair degree of overlap between the NICE draft guidance and both '*What to do if you're worried a child is being abused'* and '*Working Together to Safeguard Children'*. In terms of '*What to do if you're worried a child is being abused'* there is overlap of setting out possible signs and symptoms of abuse and neglect, and in relation to 'Working Together', there is overlap of assessment and child protection processes. In terms of the interface with 'Working Together', there is some overlap and repetition. This guide should cross-refer as much as possible to 'Working Together'. NICE should delay the publication timetable so that the guide comes out after the revised 'Working Together' is published. In terms of other points, it is unclear about what the guidelines are actually for? What is your USP? On the research recommendations, DfE consulted on the possible introduction of mandatory reporting in the 'Reporting and acting on child abuse and neglect' consultation, so it was interesting to see the recommendation on research on statutory reporting systems. DfE feedback to NICE in 2014 suggested that DfE would not favour looking at this and given the mandatory reporting consultation, response is likely to be published over the next couple of months it is slightly odd for NICE to be recommending more research.	Thank you for your comment. We have amended the introductory text for relevant sections to make clearer how this fits in with Working Together 2015 and, where relevant, What to do if you're worried a child is being abused. We have also made clearer what we consider the 'USP' of the guideline to be, namely that it is based on systematic review of the research evidence on effectiveness, cost effectiveness and service user views and experience. The research recommendation on statutory reporting duties has been removed.
Department for Education	Full	General	General	As its very detailed practice, guidance is designed to go alongside the statutory guidance like 'Working Together' and *Keeping Children Safe in Education* (KCSIE) and so future updates should not affect it too much. It does not seem to duplicate what is in the statutory documentation except in quite general terms. As far as LSCBs are concerned, it could be future-proofed by referring to 'local multi-agency safeguarding	Thank you for your comment. We have removed reference to Local Safeguarding Children Boards throughout both versions.

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		Page 37		arrangements' instead of LSCBs. And if NICE don't do that they should at least correct the name – they are calling them LCSBs in the guidance and referring to them as Local **Children's** Safeguarding Boards instead of Local Safeguarding Children Boards. The full version indicates that the same errors do not occur and NICE have sought to future-proof in that version, though they are incorrectly calling them 'Local Safeguarding Children's Boards' instead of Children, sporadically.	
Department for Education	Short	General	General	The recommendations seem sensible and the coverage on fostering and therapies seem fine. There is nothing particularly new and where NICE recommend - for example, parenting programmes, there would be associated training, which programme commissioners would purchase	Thank you for your comment.
Department for Education	Full	General	General	NICE should reiterate how important it is not to lower the bar on what constitutes good evidence, and it needs to be clear about who it's addressing - it is so basic in places. More on effective Interventions would be good.	Thank you for your comment. We have now made it clearer in the introduction that the recommendations in the guideline are based on the highest available quality evidence. The sections on early help (section 1.5) and therapeutic interventions (section 1.7) are based on effectiveness and cost-effectiveness evidence from randomised control trials.
Department for Education	Full	General Page 34 (short version)	General	Guidance is too long; it should be cut down without losing anything of substance. Will anyone read over 500 pages? NICE outline some *'pointers to help organisations to put NICE guidelines into practice'* – This has potential to be useful but it lacks substance and it would be improved by including some further detail with some practical examples, e.g. on the *'what data might be needed to measure improvement'* point - some examples should be given of the type of data organisations' may use and examples of where this has worked well? The consultation form asks for what would help users overcome any challenges. (For example, existing practical resources or national initiatives, or examples of good practice.) In addition, DfE resources on Gov.uk relating to neglect are very practical based and look very helpful in terms of helping people to understand and identify neglect. https://www.gov.uk/government/collections/childhood-neglect-training-resources In addition, the Early Intervention Foundation (EIF) cover maltreatment and has a guidebook with some specifics, which may be useful to practitioners in this area. http://guidebook.eif.org.uk/programmes-library/search?min-age=-1.00&max-age=20.00&submit=search&s= DfE will shortly publish some new research from Research in Practice called "*Evidence review: The impacts of abuse and neglect on children; and comparison of different placement options*', which NICE might like to highlight.	Thank you for your comment. There is a shorter version of the guideline (54 pages) which is the version NICE would expect pracititoners to refer to. The longer version provides details of all the evidence reviewed for those wishing to know more. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance. Thank you for your feedback regarding implementation resources. We will pass these to our colleagues in the implementation team.
Department for Education	Full	General	General	NICE have said that this guidance is aimed at people in "lead professional" roles [in education]. This implies the guidance is not directed at all teaching staff or others in daily contact with children in an education setting and would be specifically aimed at the designated safeguarding lead. Is this interpretation correct? DfE are pleased the statutory guidance '*Keeping children safe in education'* (KCSIE) is referenced throughout the guidance. However, KCSIE is a complex document, not all of which is directly relevant to all school and college staff. Even if DfE interpretation in Comment 1 is correct and the guidelines are aimed at the designated safeguarding lead only, there is still a great deal of technical content, which is not relevant to schools. A "quick checklist" of the main relevant points each target group should take away from the guidelines would be very helpful. Schools and colleges are accustomed to looking to statutory guidance KCSIE and 'Working Together' for information on how to discharge their safeguarding duties and promote the welfare of children. There is concern as to how the proposed NICE guidelines will sit alongside the existing guidance and what added value it will provide? A revised version of KCSIE will come into force in September 2017. DfE understand NICE intend to publish these guidelines to be effective from the same date. There is a concern that this may create confusion for schools and colleges.	Thank you for your comment. Different sections of the guideline are relevant for different professionals. For example, the recommendations on early help relate mostly to people in education taking on the lead professional role, whereas the recommendations on recognition are relevant to all education practitioners. We have now amended the introductory text, and the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make this clearer.
Department of Health (DH)	Short	Genersl	General	Although the scope covers children and young people at risk of abuse and neglect, the guideline is extremely light in content on this aspect.	Thank you for your comment. We aimed to make a number of recommendations

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					relating to children at risk of abuse and neglect. For example, section 1.5 highlights a interventions which have been shown to be effective in reducing the risk of abuse and neglect in this group. Section 1.2 and 1.3 highlight vulnerability factors and alerting features that should help to bring children and young people at risk of abuse and neglect to the attention of services.
Department of Health (DH)	Short	General	general	The scope covers children and young people up to 18 years. However, this does not reflect 'Working Together' which it is intended to complement in relation to vulnerable young adults. We suggest that the scope be extended.	Thank you for your comment. At the time of writing, the Working Together 2015 definition of a child is ' Anyone who has not yet reached their 18th birthday.' (p. 92). We have used the same age cut-off for consistency with this document.
Department of Health (DH)	Short	General	general	Can you review with Department for Education that this does complement 'Working Together' which is currently being refreshed.	Thank you for your comment. NICE is in communication with the Department for Education regarding the changes to Working Together.
Department of Health (DH)	Short	General	general	Could the document be strengthened around digital and social media contributing towards abuse.	Thank you for your comment. We did not find evidence regarding effective responses to abuse via digital and social media, and so did not make recommendations in this area.
Department of Health (DH)	Short	General	general	The guideline can seem unwieldy and confusing where a lot of different guidance is referenced. Professionals will not have time to read all of these as well.	Thank you for your comment. Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action.
Department of Health (DH)	Short	General	general	1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. A cultural change towards increased awareness leading to better and earlier identification of abuse and neglect, and staff feeling confident to routinely ask about abuse and neglect will be extremely challenging to healthcare professionals. Roll out of 'Seen and Heard' and routine enquiry on adverse childhood experiences will go some way to engender this culture change.	Thank you for your comment. Reference to enquiry about adverse childhood experiences has been added to recommendation 1.4.4.
Department of Health (DH)	Short	General		2. Would implementation of any of the draft recommendations have significant cost implications? Implementation should lead to increased reported cases of CSA/E which could have cost implications for health in terms of increased therapeutic support.	Thank you for your comment. The guideline committee considered carefully the resource implications of recommendations on therapeutic interventions following child sexual abuse, including considering the cost-effectiveness of the intervention. For trauma-focused CBT (recommendation 1.7.17) economic modelling using threshold analysis suggested that this was cost-effective. The psychoanalytic/psychotherapeutic therapy intervention (recommendation 1.7.19) also had some evidence to suggest that it was cost-effective. In relation to 'Letting the Future in' (recommendation 1.7.18) no cost-effectiveness evidence was available for this intervention. However, the guideline committee considered carefully the resource impact of this recommendation. They acknowledged that there was likely to be variation in the availability of this type of intervention, but that in their experience similar

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					interventions were available, often within the voluntary sector. The committee thought it was important to make a recommendation to highlight good practice, and also to provide alternatives to trauma-focused CBT, given the evidence that not all children and young people find this approach acceptable. The view of the committee was that it was appropriate to make a 'consider' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it. Recommendation 1.7.18 and 1.7.19 are 'consider' recommendations, meaning that practitioners should think about providing the intervention, rather than that they must offer it. Please see the Linking Evidence to Recommendations tables in the full guideline for more information.
Department of Health (DH)	Short	General		3. What would help users overcome any challenges (for example, existing practical resources or national initiatives, or examples of good practice)? Short, practical resources for health care professionals will be needed to support implementation, as well as the existing resources under question 1.	Thank you for your comment. We will pass your feedback to the implementation team.
Department of Health (DH)	Short	7	10-12	Is there evidence for existing tools to support critical and analytical thinking, and what this involves?	Thank you for your comment. We searched for evidence on tools to support recognition and assessment, but did not find any evidence that the guideline committee thought was sufficiently strong to base a recommendation on.
Department of Health (DH)	Short	9	1-2	Child risk factors for abuse and neglect go wider than behavioural and emotional indicators, for example, the home environment.	Thank you for your comment. Recommendation 1.2.2 has been added post consultation and makes reference to environmental vulnerability factors.
Department of Health (DH)	Short	16	10	This section should include carrying out routine enquiry on adverse childhood experiences to illicit disclosure which is being rolled out across services in the NHS. DH is happy to work with you on this section. This should recognise that people don't disclose at the first contact.	Thank you for your comment. Reference to enquiry about adverse childhood experiences has been added to recommendation 1.4.4.
Department of Health (DH)	Short	16	10	DH and NHS England have a campaign supported by a set of training materials intended to raise staff awareness of how children and young people who have been abused may experience their service. 'Seen and Heard' is easily accessible online, takes an hour to complete, and once done staff can go on to become champions. This resource would be ideal to raise awareness of all NHS staff. It is available at: https://www.seenandheard.org.uk/	Thank you for your comment. Recommendation 1.3.10 refers to the intercollegiate training document for NHS staff. We will pass the information regarding training materials to our implementation team.
Department of Health (DH)	Short	16	10-18	Only raising awareness in primary care is very narrow: all staff in the NHS should undertake safeguarding training. Every six months top-up training is not feasible or deliverable. Mandatory safeguarding training is done at induction, then every three years. We suggest you consider this model.	Thank you for your comment. This recommendation was based on specific evidence reviewed by the committee, which highlighted the importance of staff in primary care having good awareness of safeguarding issues. Recommendation 1.3.10 has been amended to align with the standards set out in the intercollegiate training document.
Department of Health (DH)	Short	18	22	This section should also include how to carry out routine enquiry of adverse childhood experiences which includes child sexual abuse and exploitation and is being piloted and rolled out in services. DH is happy to work with you on this section.	Thank you for your comment. Reference to enquiry about adverse childhood experiences has been added to recommendation 1.4.4.
Department of Health (DH)	Short	19	9	This should make clear that professionals should triangulate information from different sources to ensure an accurate assessment and plan.	Thank you for your comment. Section 1.4 on assessment now directs professionals to follow the guidance on assessment as set out in Working Together 2015. This

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					guidance makes reference to drawing together information from different sources.
Department of Health (DH)	Short	19	14	This needs to make clear what the purpose is of having access to a specialist with knowledge about children and young peoples' specific needs. How would this add value?	Thank you for your comment. This recommendation (now 1.4.6) was aimed to address the fact that the practitioner conducting an assessment in relation to abuse and neglect may not have specialist knowledge about the needs of disabled children and young people, or those with neurodevelopmental disorders, and how this may interact with the concerns that have led to them being assessed in relation to abuse and neglect. This recommendation suggests that this should be addressed by the person conducting the assessment having access to a person who is able to supply that knowledge.
Department of Health (DH)	Short	17-19		This section in particular is not accessible, and would benefit from a summary version for professionals.	Thank you for your comment. The recommendations in this section have been reviewed to make clearer at whom they are aimed. A concise 'quick guide' for professionals will also be produced. To help people to use the guideline and associated materials, NICE has also developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
Department of Health (DH)	Short	19-21		The early help section is based on very small scale studies. Is the evidence base robust enough to include them?	Thank you for your comment. The sample size is one of the factors taken in to consideration when appraising the evidence and presenting it to the guideline committee. For this question, we also used evidence from existing systematic reviews and reviews of reviews which aggregate a number of studies. The guideline committee were satisfied that the balance of evidence was sufficiently robust to support these recommendations.
Department of Health (DH)	Short	19	21	Is the evidence base around six months home visiting robust? What about the evidence for visiting in different environments?	Thank you for your comment. The recommendation that home visiting programmes should last for at least 6 months was based on the duration of the effective interventions reviewed. We did not find any evidence relating to visiting in different environments.
Department of Health (DH)	Short	22	27	Many different professionals will come into contact with children and young people affected by domestic abuse, including healthcare professionals, so this section should reflect that.	Thank you for your comment. Recommendation 1.6.3 has been amended to cross reference to more detailed guidance provided in the NICE guideline on domestic violence and abuse.
Department of Health (DH)	Short	23-27		This section on interventions is particularly light on anything around children and young people at risk of abuse and neglect: could it be strengthened?	Thank you for your comment. Section 1.5 provides a number of recommended early help interventions for children who are at risk of abuse and neglect and their families.
Department of Health (DH)	Short	23-27		The interventions include people up to age 17 years – can you set out the rationale for not including up to 18 years?	Thank you for your comment. The age definition in our guideline was aligned to Working Together 2015 (current version at time of scoping), which defines as a child anyone who has not yet reached their 18th birthday. At age 18 a person would cease to be defined by Working Together 2015 as a child, and so would be outwith the

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					scope of this guideline.
Department of Health (DH)	Short	23-27		Consideration should be given to trauma focussed interventions if it has not been already.	Thank you for your comment. Recommendations 1.7.15, 1.7.16 refer to trauma-informed group parenting interventions, and recommendation 1.7.17 refers to trauma-focused cognitive behavioural therapy.
Department of Health (DH)	Short	23-27		Consideration should be given to the role of Improving Access to Psychological Therapies and Children and Young Peoples' Improving Access to Psychological Therapies programmes if it has not been already.	Thank you for your comment. The view of the committee was that making clear that these recommendations are aimed at child and adolescent mental health practitioners would include those working as part of the Children and Young People's Improving Access to Psychological Therapies programme.
Department of Health (DH)	Short	23-27		It would be useful to reference the NICE mental health and Post Traumatic Stress Disorder guidelines.	The guideline committee considered a range of other guidelines as part of the development of this guideline, including the NICE guideline on post traumatic stress disorder. The recommendations from the guideline on PTSD were mapped against our recommendations. A decision was taken not to cross-refer as our target population is slightly different (children who have experienced sexual abuse, not all of whom will have PTSD).
Department of Health (DH)	Short	23-27		This section is poorly structured and confusing, and there is a gap between interventions for the very young, and those aged five and above.	Thank you for your comment. This section has been restructured, and a diagram produced to show which interventions have been found to be suitable for which age groups.
Department of Health (DH)	Short	27	23-25	It would be useful for commissioners if there was any evidence to support a minimum number of sessions of therapy sessions.	Thank you for your comment. The minimum number of therapy sessions in each case is taken from the research evidence. For more information see the Linking Evidence to Recommendations tables in the full guideline document.
Department of Health (DH)	Short	28	11-13	This should also include honour-based violence as a form of abuse.	Thank you for your comment. This recommendation (1.8.3) has been amended following consultation feedback to make reference to honour-based abuse.
Department of Health (DH)	Short	28	16	Information sharing should be stronger and set out exactly when to share information and in respect of patient confidentiality when not to – the default should be to share.	Thank you for your comment. The guideline committee's view was that there is existing clear guidance on information sharing, which we have referred to here. The principal focus of this recommendation, based on the evidence we reviewed, was to emphasise the duty of orgnaisations to remove obstacles to information sharing.
Department of Health (DH)	Short	28	16-23	This section on information sharing should be strengthened to make it clear when to share information – DH (with NHS England Safeguarding) would be happy to advise on this.	Thank you for your comment. The guideline committee's view was that there is existing clear guidance on information sharing, which we have referred to here. This recommendation has therefore been removed.
Department of Health (DH)	Short	28	16-23	There is also other guidance on information sharing that should be referenced for example by the Royal Colleges, as well as the joint letter issued by Government Departments on when to share information at: https://www.gov.uk/government/publications/tackling-child-sexual-exploitation--2	Thank you for your comment. The recommendation on information sharing has been removed, following consultation feedback that there is significant existing guidance in this area.
Department of Health (DH)	Short	28	14	It would be helpful to set out what is meant by those providing universal services: for example, does this mean those that are most likely to come into contact with children and young people (teachers, GPs)?	Thank you for your comment. This recommendation has been reworded to refer more clearly to the threshold document. Working Together 2015 makes

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					it clear that this should be published and shared widely, so we have omitted reference to 'communicating to all agencies, including those providing universal services'.
Department of Health (DH)	Short	29	7	It would be helpful to set out what 'stay in touch' means.	Thank you for your comment. This recommendation has now been removed, as the specific recommendation relating to co-location has also been removed.
Department of Health (DH)	Short	29	8-14	It would be helpful to set out the recommended frequency of staff support and supervision and professions it might cover.	Thank you for your comment. We did not find any evidence relating to frequency of supervision. Recommendation 1.8.5 is intended to apply to all staff working with children and families at risk of or experiencing abuse and neglect.
Department of Health (DH)	Short	27-29		The section on planning and delivering services is very statutory secondary care focussed and ignores other services available to victims and survivors such as sexual assault referral centres and the third sector.	Thank you for your comment. The recommendations in this section are based on the evidence identified via our review question and evidence search about organisational and strategic factors that support effective responses to child abuse and neglect.
Doncaster Safeguarding Children's Board		General		The document raises a number of practice issues for the DSCB- In our opinion the structure of the document is likely to misguide practitioners into referring children into Social Care without consideration to offering early help in the first instance. It is our opinion that There should be more of an emphasis on the expectations of the multi-agency responsibility around early help at the begging of the document rather than towards the end The document does not clearly identify what an early help offer should look like nor does it place any responsibility on partner agencies to undertake assessments of potential risks of abuse through Early Help/ CAF assessments. Given the above there is a concern that this could lead to a significant increase in the referral rate to Social Care potentially leading to unnecessary statutory intervention into family life. The document fails consider the importance of empowering parents to deliver self-directed support and safety planning for their children. The emphasis the document is about "doing to" families rather than with. The document fails to define the role that Multi-agency professionals have in achieving this and empowering families to make positive changes. The document suggests visiting patterns to families that are far in excess of current statutory guidance which will severely impact on the current Social Work capacity available. There seems to be a lack of evidence base around the information included in the guidance. It doesn't include the use of models such as MST-CAN or Signs of safety which have a strong evidence base. Also it doesn't appear to allow for a local focus. It's unclear where the need for the guidance has come from given that 'Working Together' has been shortened to remove guidance , has this guidance been written to fill the void left by the shortened version of Working Together?	Thank you for your comment. We have added text in to the section on 'alerting features' highlighting that early help assessment may be an effective response to alerting features. Section 1.4 makes recommendations in relation to early help assessment, and Section 1.5 makes recomemndations about interventions that have been shown to be effective at the early help stage. Recommendations 1.1.10 and 1.1.11 refer to good practice in working with parents and carers. Following consultation feedback, reference to empowering families has been added to recommendation 1.1.10. The frequency of visits (for example in relation to early help home visiting in recommendation 1.5.13) are based on research evidence. This recommendation relates to early help rather than statutory involvement. The guideline has been developed making use of a range of sources of evidence, including the views of children, young people, their parents and carers; evidence on what interventions are effective in working with children and young people at risk of, or who have experienced, abuse and neglect and their families and carers (evidence from randomised and quasi-randomised control trials); and evidence on what helps and hinders professional practice in working with this group. This included evidence from syntheses of Serious Case Review data.Recommendation 1.7.14 recommends MST-CAN. We screened evidence on Signs of Safety but it did not meet our inclusion criteria.
Doncaster Safeguarding Children's Board	Short	4	14 1.1.1	Principals for working with C/Y and families should include risk managing at the lowest level – Messages from Research around engagement with families – solution focussed approach to risk management	Thank you for your comment. The committee's recommendations were based on the research reviewed.

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Doncaster Safeguarding Children's Board	Short	5	24 1.16	Producing written record of the conversation with the child and sign off of both to agree content. Massive implication for practice as recording is currently completed after the event SW are recording children's actual comments but to achieve sign off would require investment. Potential Solution - direct work could be completed on a tablet to enable sign off but would not include phone calls – If we are doing this with children / YP we should also be doing it with their Parents.	Thank you for your comment. Following consultation comments, we have amended recommendation 1.1.6 to say that the record of the conversation could be in another format. Reference to sharing documents and plans with parents has been added to recommendation 1.1.11.
Doncaster Safeguarding Children's Board	Short	6	28 1.1.17	Sharing reports / plans with parents and children Current practice would be that the reports / plans are shared with parents and young people. As part of Signs of Safety model of practice child centred safety plans are embedded further work is required to ensure every child has their own developed plan- Training implication	Thank you for your comment. Recommendations 1.1.7 and 1.1.11 make reference to sharing plans with children and parents respectively. It is encouraging that this is already part of practice in your area.
Doncaster Safeguarding Children's Board	short	6	15 1.12	Working with parents and carers principals are good however it does not talk about empowering parents / families in developing their own self-directed support / safety plan. Solutions to challenges are often best achieved through family engagement and self-directed planning	Thank you for your comment. Reference to empowering parents and involving them in finding solutions has been added to recommendation 1.1.10.
Doncaster Safeguarding Children's Board	short	7	6 1.1.13	Working with professionals principals are good however reduction in capacity within the multi-agency has meant MA planning does not always have appropriate representation. For example HV input into core groups, Police reps at review conf- the impact on social work practice is that often SW are undertaking all the tasks agreed within the plan	Thank you for your comment. We recognise the resource constraints in many areas. However, Working Together 2015 makes clear the duty on services to work together.
Doncaster Safeguarding Children's Board	short	7	17	The document does distinguish between Consider and suspect but offers no detail about distinguishing between the two and offers no clear guidance on when to refer to Social Care for assessment. Needs to be clearer about when referrals should be made – likely impact is that referral rate to Social Care will significantly increase leading to statutory intervention into family life inappropriately. There will be a significant impact upon social work capacity ensuring the right children receive the right service at the right time.	Thank you for your comment. We have added explanatory text in to the introduction to this section about the difference between 'consider' and 'suspect' and the different actions associated with each. We have made it clearer that only 'suspect' recommendations should immediately lead to a referral.
Doncaster Safeguarding Children's Board	Short	8	10 1.2.3	Children's behaviour needs expanding – some children's behaviour is challenging for other reasons other than neglect / Abuse e.g poor parenting disability may not always be an indicator of abuse need to be in context.	Thank you for your comment. We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'Alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to be curious about behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
Doncaster Safeguarding Children's Board	Short	8	14 1.2.5	Potentially could be misleading causing possible prejudice does not preclude asking children questions e.g how a bruise was caused. Not asking questions could lead children and their families inappropriately experiencing statutory intervention.	Thank you for your comment. We agree that it is important for practitioners to ask questions, and recommendation 1.3.5 recommends that practitioners do explore their concerns in a non-leading way.
Doncaster Safeguarding Children's Board	Short	9	4 1.2.9	Parental Risk factors –although these are risks the question is how this impacts on the child – nor does it ask the question if there is a protective parent around. There is a potential for increased referral rates to SC that will have significant impact on capacity to deliver quality interventions into family life. The whole paragraph is written is an oppressive way	Thank you for your comment. The aim of this section is to provide information on features which should alert practitioners to the possibility of abuse or neglect. We would expect protective factors to be considered as part of an assessment, as outlined in Working Together 2015. The section on assessment (Section 1.4) references Working Together guidance.
Doncaster Safeguarding Children's Board	Short	10	3	Emotional Indicators – Children do react to stressful situations as described but is not always an indicators of A&N – it would be more worrying if children did not react in this way in stressful situations ie divorce / separation of parents, bereavement	Thank you for your comment. We have added text in the introduction to this section highlighting that there may be other explanations for the behaviours described.
Doncaster Safeguarding Children's Board	Short	14	5 1.2.30	Need to add emotional harm to this list – however this behaviour could be as a consequence of poor parenting not A&N	Thank you for your comment. The features described here are based on the evidence reviewed. The wording 'consider' implies

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					that professionals should gather more information before acting further.
Doncaster Safeguarding Children's Board	Short	15	15 1.2.4	A&N should be considered were parents fail to engage with health promotion programmes ie immunisations. –there is no comment about Parental choice suggested that A&N should be considered however this should be seen in a context not prescriptive – the guidance offers no alternative suggestion for managing this through health and potentially could result in children been referred to statutory services.	Thank you for your comment. We acknowledge that immunisation is voluntary. However, the evidence reviewed for the NICE guideline on child maltreatment from which this is taken suggested that this behaviour can be an indicator of abuse and neglect. The wording 'consider' implies that professionals should gather more information before acting further.
Doncaster Safeguarding Children's Board	Short	17	16	No suggestion that other agencies should complete an assessment to determine potential risk(?CAF/ EHA)document states that SW role is around assessing risk however analysing a child's situation set against information gained is all professionals business – Safeguarding is everyone's business- the way the document is written will lead to professional referring children into social care inappropriately for statutory assessment. This will have a significant impact on SW capacity to respond There is no mention of Police involvement in this document Joint section 47 Investigations.	Thank you for your comment. We have aimed in the introductory text to section 1.4 to make clear that these recommendations apply to both early help and statutory assessments, and that early help assessments can be undertaken by anyone in the lead professional role. We have clarified in the introductory text who would undertake different kinds of assessments, including police.
Doncaster Safeguarding Children's Board	Short	18	22 1.3.5	Who would deliver the training? The training should be made available to all agencies not just Social care.	Thank you for your comment. This recommendation has now been removed as it overlaps with other forms of safeguarding training.
Doncaster Safeguarding Children's Board	Short	19	9 1.3.9	No suggestion around self-directed support or safety plans this is written in a way that planning is done to families rather than with.	Thank you for your comment. Reference to empowering parents and involving them in finding solutions has been added to recommendation 1.1.10.
Doncaster Safeguarding Children's Board	Short	19	14 1.3.10	Access to Specialist help therapeutic intervention for disabled children will be difficult to achieve given CAHM's capacity locally	Thank you for your comment. This recommendation makes reference to making use of specialist knowledge in relation to disabilities when assessing the needs of a disabled child in relation to abuse and neglect, rather than the provision of a therapeutic response.
Doncaster Safeguarding Children's Board	Short	19	2 1.4.1	Programme of 6 Monthly visiting to families at risk of abuse or neglect or families where with previous confirmed abuse – offers no suggestion about who should do this other than health or social Care will have significant impact on social work capacity and would require voluntary engagement by parents.	Thank you for your comment. We have amended recommendation 1.5.16 to make it clear that the main criteria for who delivers the intervention is that they are trained in the intervention, not whether they have a health or social care background. The view of the committee was that arrangements for provision were likely to be different across localities. For example, in some areas home visiting may be delivered by the voluntary and community sector. The recommendation that these interventions should last for 6 months is based on the evidence reviewed by the committee. We have also added in recommendations 1.5.2 and 1.5.3 relating to engaging with parents about the choice of intervention.
Doncaster Safeguarding Children's Board	Short	20	13 1.4.5	There are some parenting programs currently available but need to review current offer to meet the standards. If the current courses don't meet those standards who will fund additional?	Thank you for your comment. Tthe committee carefully considered the resource implications of these recommendations (1.5.7 to 1.5.12). These are 'consider' rather than 'offer' recommendations, reflecting that practitioners should think about providing the intervention, rather than that they must offer it.However, the view of the committee was that it was important to recommend

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					what types of interventions which have been shown to be effective.
Doncaster Safeguarding Children's Board	Short	22	14-25	This would have significant impact on Social Work delivery, would need to do a skills audit ad identify social work skills gap and provide training. Need to consider multi agency involvement here too.	Thank you for your comment. This recommendation (now 1.6.2) has been reworded to make clear that achieving these outcomes would be the responsibility of all practitioners working with children who have been assessed as 'in need' or suffering/likely to suffer significant harm, with co-ordination by the social worker, as outlined in Working Together 2015.
Doncaster Safeguarding Children's Board	Short	23	8 1.6	Therapeutic interventions for C,YP and families after Abuse and neglect Whole paragraph outlines interventions to be offered to families Significant work required with partner agencies who is to deliver this work – attachment based therapeutic work and Psychotherapy Will require additional training for Social Workers around attachment based intervention models and clear local guidance for CAHM's given the current capacity and waiting times for CAHM's involvement	Thank you for your comment. The introduction to this section now makes clearer who these recommendations are aimed at. The guideline committee considered carefully the resource impact of these recommendations, in light of current local constraints. Most of the recommendations are worded 'consider', reflecting that practitioners should think about providing the intervention, rather than that they must offer it.
Doncaster Safeguarding Children's Board	Short	25	1	Expectation of weekly visits for minimum 6 months not realistic. Have Social Workers got the capacity to visit so frequently over extended period of time.	Thank you for your comment. The guideline committee considered carefully the resource impact of the recommendations on home visiting. This is a 'consider' rather than an 'offer' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it. However, the committee thought it was important to make this recommendation based on the evidence of effectiveness of many home visiting programmes. Although there was not conclusive evidence of cost-effectiveness, the committee also considered the potential costs of not intervening in families showing possible early signs of abuse and neglect, in terms of the potential for problems to become more serious and to result in greater service use and other costs in the future. The view of the committee was also that many local areas do already offer these interventions, and so there should not be a significant additional cost in implementing these. The recommendation that these should last for 6 months is based on the evidence reviewed by the committee.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	Full	General	General	The group discussed the overall size of the document , felt people could be overwhelmed possibly leading staff not to read it.	Thank you for your comment. There is a shorter version of the guideline (54 pages) which is the version NICE would expect practitioners to refer to. The longer version provides details of all the evidence reviewed for those wishing to know more. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
Dorset LSCB Dorset CCG Wessex NHS	Full	General		How does this relate to statutory guidance? potential for confusion , a Paediatrician comment felt they should have this depth of information and the links are important, some felt bullet points would be good with examples of good practice	Thank you for your comment. Additional detail has been added to the introductory text, and in the introductions to sections

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Southampton CCG					1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	General			Concern that it felt lack of capacity within current services to be able to deliver this level of intervention, feeling it was quite distance from reality as to what areas currently have in place ..providers could be challenged in SCR as Nice is often used as best practice , there is a national lac of therapeutic intervention this reads as it is the normal to have specialist services readily available, the concern expressed Is we could be setting up practitioners to fail without the right services in place. Recommendations seen as aspirational, as they are specific about duration and types of program to be delivered , some programs are not delivered locally or even available in some regions	Thank you for your comment. The guideline committee considered carefully the resource impact of the recommendations, taking in to account cost effectiveness evidence and economic modelling where available, and also the availability of the recommended interventions. The committee recognised that the recommended interventions are currently not available in all areas however, they thought it was important to highlight which interventions are effective based on the effectiveness evidence (and cost-effectiveness where available). The majority of recommendations are worded as 'consider', meaning that practitioners should think about providing the intervention, rather than that they must offer it.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	Full		1.1.1.	Take a child centre approach to work with children and young people :involved them in decision –making to the fullest extent possible depending on their age and development stage.	Thank you for your comment.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	full		1.1.3	In all conversation with children and young people explain confidentiality :be sensitive and empathic …	Thank you for your comment.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	full	18	1.2.24 1.2.5:	Possible change of wording, could this read as poor standard of hygiene could affect a child health's Explore your concerns with children and young people in a non-leading way and avoid causing prejudice to any formal investigation during early conversations. Taking a child centred approach to all aspects of working with children: including in all conversations the elements, explore their views and assure what happened next will prove to have an enormous impact on practice . Frequently in practice it is the child's voice and wishes feelings that have not been understood as part of the referral :assessment and child protection process> there is some mixed quality of evidence from uk studies (ref pg 187) that assessment of risk and need in relation to child abuse and neglect hindered by not directly specking to and the observing children and young people	Thank you for your comment. Recommendation 1.2.24 (now 1.3.24) is intended to refer to a poor standard of hygiene that affects a child's health. Recommendation 1.4.1 aims to address evidence that children's wishes and feelings are not always understood, by recommending that children are always communicated with and observed directly.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	full	111, 1.13, 1.2.2.4 and 1.25		Collectively we primarily formed view recommendations about the style of working with children a young people and would not require significant investment in resources. Although many staff working directly with children will have the competency through their route of professional registration , development and training to achieve this recommendation in practice there will be a broad spectrum of professionals who will need specific training an implementation the child centre approach	Thank you for your comment.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	full	21	1.3.37 1.2.42	These recommendations assume that practitioners are seeing parent and child interactions Consider neglect if parents or cares fail to attend follow up appointments.	Thank you for your comment.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	full		1.2.37	Recognise that excessive physical punishment constitutes physical abuse …we all agreed the word excessive should be removed completely	Thank you for your comment. This recommendation has been removed following consultation feedback.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	full		1.2.46	Ensure all practitioners in primary care can recognise and response to child abuse and neglect , sexual indicators and child trafficking /CSE. On-going challenge to provide all practitioners within the primary care (acute, independent and adult services) in recognition and response. Although no evidence was available to inform these guideline recommendations, the guideline committee were mindful of the potential costs and resources use when making the recommendations. Practitioners will need to recognise and respond in line with the competencies detailed for their role and responsibilities within the Intercollegiate document (2014). This provides a continuous challenge to organisations to ensure staff are competent due to delivery and access to training while maintain health provision.	Thank you for your comment. This recommendation (now 1.3.10) has been amended to align with the intercollegiate document.

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Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	full		1.4.1 and 1.7.1	There a number of recommendations which enormous cost implement these two areas of concern for the delivery of health services. Consider a programme of home visits , lasting at least 6 months , for parents or cares at risk of abusing or neglecting their children . this includes parents or cares with previously confirmed instances of abuse and neglect .the evidence was taken from the reviews of effectiveness of early help interventions . Although the economic analysis was inconclusive, the view was that home visiting was a commonly provided model of care would not require significant additional investment. Many of the current home visiting programmes are managed on a universal: universal plus or targeted basis and do not offer the intensive programme of home visiting as recommended. This recommendation has significant cost implications based on the gap between current service provided and those recommended . Additional numbers of qualified health staff will be required to fulfil this recommendation in both midwifery an school nursing and health visiting. Re parenting programme for parents or cares at risk of abusing or neglectful their child or children ;lack of suitable economic evidence to inform these guidelines recommendations .. Although the cost –effectiveness evidence was inclusive :the guideline view was that parenting programmes are already often provide and so implementation would not be required	Thank you for your comment. The guideline committee considered carefully the cost-effectiveness and resource impact of the recommendations on home visiting and parenting programmes. Both of these are 'consider' rather than an 'offer' recommendations, meaning that practitioners should think about providing the intervention, rather than that they must offer it. However, the committee thought it was important to make the recommendations based on the effectiveness evidence as a way of promoting good practice. Although there was not conclusive evidence of cost-effectiveness, the committee also considered the potential costs of not intervening in families showing possible early signs of abuse and neglect, in terms of the potential for problems to become more serious and to result in greater service use and other costs in the future. The view of the committee was also that many local areas do already offer these interventions, and so there should not be a significant additional cost in implementing these.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	full		1.6.4.	Offer an attachment –based interventions to parents who have neglected or physically abused a child under 5 to be delivered in parents or cares home , consider this in line when the family is exposed to Domestic violence	Thank you for your comment. The target group for this recommendation is based on where evidence has shown this intervention to be effective. We have not reviewed evidence on the effectiveness of these interventions in cases where children and families have been exposed to domestic violence, and so were unable to recommend this for this group.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	Full	General	general	**We would like to hear your views on these questions:** **1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why**. **.** Commissioning evidence-based specialist services for those children experiencing severe neglect and trauma post-abuse will be particularly challenging. The availability of these interventions is currently patchy at best and demand outstrips supply. In addition insufficient numbers of practitioners and clinicians are trained in their delivery. Services for parents with drug and alcohol problems, including those with a dual diagnosis, and those with chronic mental health difficulties are also being cut due to funding problems and are urgently needed to prevent child abuse. In our experience many practitioners have limited knowledge of the range of effective interventions available and selecting the most appropriate intervention is therefore challenging. The guidance is aspirational rather than based on a realistic assessment of current capacity and resource constraints. Having aspirations for children is admirable but we fear that within the current financial envelope the guidance risks setting up services and individuals to fail. The guidance could be used as a measure to hold providers accountable when delivering specialist long term interventions which are not available throughout the country. The guidance talks about co-location and integrative working. These are still very much in their infancy and it seems that assumptions have been made about the current state of services and working practices	Thank you for your comment. The guideline committee acknowledge the financial contrainsts in many parts of the sector, and considered carefully the resource impact of the recommendations, including making use of cost-effectiveness evidence and economic modelling data where available, and the practice experience of committee members regarding currently available provision. Although it was acknowledged that many of the recommendations may have some resource implications, the committee thought it was important to make recommendations as a means of highlighting what evidence suggests is best practice.. The majority of interventions recommendations are worded as 'consider' recommendations, meaning that practitioners should think about providing the intervention, rather than that they must offer it. The recommendation on co-location has been removed following consultation feedback.
Dorset LSCB	Full	general	general	2. **Would implementation of any of the draft recommendations have significant cost implications**?	Thank you for your comment. The

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Dorset CCG Wessex NHS Southampton CCG				If all the recommendations were to be met it would have significant cost implications both in financial terms and in terms of staff capacity. Addressing the shortfall in the availability of evidence-based therapeutic interventions for children and parents will have significant cost implications. The costs of providing specialist targeted therapeutic interventions are a concern. A number of programmes that have been rigorously evaluated can only be delivered on licence and the costs, including those of training staff in their delivery, are considerable (eg Triple P or MST-CAN). Training all child protection practitioners in different disciplines to meet the standards in the guidance will be costly. This is in the context of significant reductions in organisational training budgets. Multi-agency training would be particularly beneficial but is seriously under-resourced at present. The GC considered evidence on cost-effectiveness and economic modelling, as well as the potential resource impact of potential interventions. For all interventions, the committee considered the potential costs of not intervening, in terms of the potential for problems to become more serious and to result in greater service use and other costs in the future. The view of the GC was that the recommendations in the final guideline are aspirational but achievable.	guideline committee acknowledged the financial contrainsts in many parts of the sector, and considered carefully the resource impact of the recommendations, including making use of cost effectiveness and economic modelling evidence where available. Where cost-effectiveness evidence or economic modelling was not available, the committee made 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence, as a way of promoting good practice. 'Consider' means that practitioners should think about providing the intervention, rather than that they must offer it. The committee also took in to account the availability of therapeutic interventions. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Given all these considerations, the recommendations were felt by the GC to be aspirational but achievable.
Dorset LSCB Dorset CCG Wessex NHS Southampton CCG	**Full**	General	general	**3. What would help users overcome any challenges?** The audience for the guidance would benefit from further clarification. It is written as if for front-line practitioners and providers, but providers cannot implement this level of change in service delivery alone - it needs to be written in a way that also addresses commissioners from Health, LA and Public Health. In our experience those outside of health (e.g social care and education) are less aware than those in health related disciplines that the NICE guidance is intended for them. The guidance – even the short version – is too lengthy for practitioners to read. It would benefit from being re-written with sections targeted at different audiences, such as commissioners of services and practitioners, having summaries of key points with the very useful links, as now, to more in depth coverage. It would be helpful to clarify the status of the guidance and its relationship to statutory guidance such as Working Together. A coordinated and funded dissemination and training programme is needed to ensure effective implementation of the guidance. These should be multi-disciplinary wherever possible. BASPCAN would be interested in supporting such a programme. A training strategy should include awareness raising; training in how to determine which interventions are likely to be most effective for which forms of abuse and in what circumstances; and, training to deliver specialist evidence-based interventions. The training needs of first line managers, supervisors, designated and named professionals should not be ignored. A database or repository of information about different evidence-based interventions for parents and children would be of great value. This would need to be maintained and kept up to date. The California Clearing House provides an example of how this can work.	Thank you for your comment. Following stakeholder feedback, we have worked to make the short guideline more user-friendly, including setting out which sections are relevant for different audiences. A concise 'quick guide' version of the guideline for practitioners will also be developed. To help people to use the guideline and associated materials, NICE has also developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
Esoteric Practitioners Association (EPA)	**Full**	General	General	The EPA recognises that these guidelines are produced for the specific purpose to ensure that professionals working with children are as well informed as possible; identifying potential abuse and understanding what steps to take should abuse be suspected or disclosed. In the current political and financial climate, it is more difficult than ever for professionals dealing with abuse to take all the necessary steps to safeguard and protect the welfare of children.	Thank you for your comment. As you note, we hope that the guidelines will support practitioners to undertake the most effective and cost-effective responses, given the current climate.
Esoteric Practitioners Association (EPA)	Full	General	General	We welcome these guidelines as necessary and useful. However the EPA feels that this report does not go far enough in recommending support and guidelines for those who work with vulnerable children. We are concerned that there is abuse and neglect happening to staff, with unreasonable work demands, in addition to a serious lack of supervision. One social work manager writes: *'At one point we had so many unallocated cases that the senior manager was concerned, but he was more worried about how it made the service look rather than the impact on staff, their stress levels, children and their families. Most*	Thank you for your comment. Recommendation 1.8.5 relates to supervision of staff, which we recognise is crucial to supporting professional judgement and the wellbeing of professionals.

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				staff were working in the evening, at weekends and when they were on leave. He tried to bully us to tell staff to close 4 cases a week so we could allocate and reduce the caseload in a week, which was a physical impossibility. We pointed out the risk, which he just ignored. He even sat in our office for a day and tried to pile on the pressure.' Every unallocated case is a child and family with an unknown level of risk. We would like to see more research commissioned into these concerns. More qualitative data is needed from professionals to get a true picture of what is actually happening for staff, how they are being treated and the potential for this to have a detrimental impact upon the children whose lives they are required to make crucial decisions on behalf of.	
Esoteric Practitioners Association (EPA)	Full	28	10 to 20	The EPA is concerned that the current system itself, its processes and procedures can actually be abusive and traumatic to the very children they are designed to support. We recognise that there are basic criteria that must be achieved to ensure the protection and wellbeing of children. However, we are concerned that there are times when this criteria has become just a tick box exercise for the professionals involved, and that there is not enough focus on maintaining the wellbeing and ongoing healthy development of the child, during some of these traumatic interventions. For example one professional working with children writes: *'Children were going to be placed into the care of foster carers. On the day this was to happen these new carers had told the social worker that they needed to pick up their dogs first so please could the children be dropped off at 7pm. The social worker arrived with the children at 6.15pm. These children who had just been taken from their mother were sitting in a car with a social worker they didn't know, outside a house they were now going to call home, with black bin bags of their few possessions. It was cold and dark and they were afraid. What kind of welcome was this to a new home? These same children have now had two different social workers in rapid succession and they are only 8 weeks into their placement.*' It is important to note that these moments stay with a child and impact every further relationship. There is undoubtedly an impact on self worth, self-esteem, confidence and security. A child under these circumstances would feel undervalued and uncared for especially given they have just been taken away from their family. This one example illustrates how the system is perpetuating the abuse of vulnerable children. We are concerned that the current climate in which professionals are working does not allow adequate consideration and intervention to ensure the child's wellbeing and ongoing healthy development at every step of professional involvement.	Thank you for your comment. We agree that the wellbeing of children and young people must be the focus of safeguarding work, and recommendation 1.1.1 highlights the importance of a child-centred approach. Recommendation 1.1.13 aims to encourage critical thinking and avoid 'tick box' thinking.
Esoteric Practitioners Association (EPA)	Full	12	28	This recommendation will be a challenging change in practice due to professionals' overwhelming caseloads, they do not have the capacity to 'be reliable and available as promised' when 'working with parents and carers.' This impacts greatly on relationship building and can cause frustration, animosity and a breakdown in communication – which are high-risk barriers to collaborative working. Families on Child in Need or Child Protection plans are often being asked to make significant changes to their parenting in order to safeguard children and young people. Our experience as professionals is that it is very difficult to expect or enable families to make the necessary changes without being able to offer adequate resources and support to do so.	Thank you for your comment. Your professional experiences matches the evidence we found about parents and carers' experiences of working with services. We acknowledge the resource impacts, but the view of the committee was that being reliable and available is good practice.
Esoteric Practitioners Association (EPA)	Full	28	4	Time constraints prohibit professionals from building relationships with other practitioners working with a family. It has long been found that lack of communication between professionals is known to be a high risk behavior that can result in child deaths: We are now 17 years and 10 years on from the key findings of the Victoria Climbie inquiry by Lord Laming and the second Laming inquiry ordered after Baby P's death and yet we are in the same perilous situation of having poor communication between professionals and families.	Thank you for your comment. We acknowledge that implementing this recommendation may be difficult. However, there was clear evidence from research with parents and families about the importance of having a good relationship with their workers.
Esoteric Practitioners Association (EPA)	Full	33	21, 22	Given many vulnerable families take time to trust and build relationships, the recommendation that children, young people, parents and carers work with the same professionals over time is welcomed. However, in practice this is difficult to deliver when high stress levels result in high staff turn-over. There is little continuity of care and families often	Thank you for your comment. As above, we acknowledge that implementing this recommendation may be difficult.

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				complain of being unsupported. Decisions are made for short-term gain and in order to hit targets rather than for long term true social benefit. In terms of the cost implications of any changes in protocol from the guideline recommendations, it is imperative to look beyond short-term solutions and be prepared to consider that whilst our professionals are working in a risk adverse climate, they are unable to provide basic support to our vulnerable young people. The relationship between the mental health state of staff is inexorably related to the quality of care they are able to give the children and families relying on their need to make astute decisions when assessing the needs of children. If professional's mental health state is disregarded, the abuse and neglect is perpetuated. This can result in long-term abuse to children, let down by a system that does not reflect a model of care and non-abuse, growing up with on going needs and mental health issues and a continuous need to draw on public funds for ongoing care - an indefinably high cost cycle to society.	However, there was clear evidence from research with parents and families about the importance of having a good relationship with their workers.
Esoteric Practitioners Association (EPA)	Full	25	18 19 20	This recommendation will be a challenging change in practice because of the lack of current funding for resources and available provision. In our extensive experience as a group of professionals the proposal of a six month (minimum) programme would not be beneficial for most families, as this will not realistically allow them the time to embed the positive changes that need to be made. In order for this to happen there would need to be significant funding in long-term support.	Thank you for your comment. The guideline committee considered carefully the cost-effectiveness and resource impact of the recommendations on home visiting. This is a 'consider' rather than an 'offer' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it. However, the committee thought it was important to make this recommendation based on the evidence of effectiveness of many home visiting programmes. Although there was not conclusive evidence of cost-effectiveness, the committee also considered the potential costs of not intervening in families showing possible early signs of abuse and neglect, in terms of the potential for problems to become more serious and to result in greater service use and other costs in the future. The view of the committee was also that many local areas do already offer these interventions, and so there should not be a significant additional cost in implementing these. The recommendation that these should last for 6 months is based on the evidence reviewed by the committee.
Esoteric Practitioners Association (EPA)	Full	26	9	Parenting programmes are a much-needed resource and can provide parents with necessary skills, introduce them to other parents who can provide support and let them know they are not the only ones in their predicament. However, one professional has mentioned: *'Having seen the Early Help budget significantly cut and parenting programmes rolled out as an alternative way of meeting the needs of families, it is indicative that this solution has not worked as parenting programmes are often cancelled due to low numbers. For parents/carers to access support groups a certain level of confidence needs to be in place. Many parents/carers suffer from social anxiety so it is easier for them to confide in one worker who comes to their home at their convenience. This is very different to being asked to get transport to a group, perhaps find child care and then discuss personal information in a room of people they do not know. This takes a high level of trust and confidence.'* Support to attend appointments, and especially continued support to build long term change in families is not possible due to current limited resources.	Thank you for your comment. Recommendation 1.5.4 recommends that early help should include support to attend appointments. There are also several recommendations relating to interventions which can be delivered in a person's home (1.5.13 to 1.5.16).

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Esoteric Practitioners Association (EPA)	Full	29	7,8,9	Being offered a choice of interventions to suit the person would greatly honour them and their autonomy but this is currently not possible given the current lack of resources.	Thank you for your comment. Recommendation 1.5.3 makes reference to giving people a choice of proposed interventions 'if possible' in recognition that this may not always be possible due to resource constraints.
Esoteric Practitioners Association (EPA)	Full	10	14	'Taking a child-centred approach' - In the introduction of the draft guidelines it states in the last year there were 621,470 referrals in just 1 year with 50,310 children on a protection plan. Whilst the focus claims a child centred approach, on the ground there is no consistency simply because there is a lack of resources to implement this approach. Such examples are: Waiting lists in one borough for 100 young people wanting counselling is increasing. With increasing statistical prevalence with ill mental health, including children at the age of 8 or 9 experiencing depression it is clear that our child centred approach has not been working for a very long time. *A looked after child who was finally starting to find some stability in a semi-independent home had to be moved one month before her GCSE's. The young person had no permanent place to go because the local authority was not referring young people due to lack of resources.*	Thank you for your comment. We hope that the guideline will help to make child-centred working a reality in practice.
Esoteric Practitioners Association (EPA)	Full	13	13	'Recognising Neglect and Abuse' – At present it appears we do not appreciate the long-term effect of neglect and abuse on children and young people and this includes the system that is set up to protect them. There is no significant improvement to outcomes for children and young people, which is an ineffective use of public money. The NSPCC reports that children in care are 4 times more likely to have mental health difficulties, are less likely to do well at school, can experience further abuse and neglect while in care. At the age of 19 more than twice the level of care leavers are not in education, employment or training compared to the general population. The number of children in care has risen steadily over recent years. The cost of failed reunification with families costs £300m every year. https://www.nspcc.org.uk/preventing-abuse/child-protection-system/children-in-care/ What cannot be measured in monetary terms is the loss of this child's engagement with society, and close relationships, culminating in the loss of their potential and unique expression. Early intervention and prevention is essential to making long-term changes to the lives of children who are vulnerable to neglect and abuse. Practitioners are experiencing very high work-loads leading to burn out, exhaustion and being demoralised which affects the quality of care being delivered. Which includes not being able to give the quality of time to truly address what is needed. Care takes time, as does the building of relationships. The complexity of the system needs to be addressed and to be made more about people and less about systems. If the system was more nurturing, caring and supportive of practitioners and professionals we could begin to stop the merry-go-round of exhaustion and stress, and instead lay a far more consistent and stable foundation for professionals and service users, which could ultimately reduce the costs to society. The NICE Guidelines could recommend substantial focus be given to the nurturing of staff through organisational support that encourages personal responsibility and reflects its benefit for not just the staff member themselves, the team and the organisation, but also the influence of this reflection as a counter to the abuse that the child has known thus far. An opportunity to break the potential for a life long cycle of abuse or unresolved trauma from abuse.	Thank you for your comment. The context section for the guideline highlights some of the long term impacts of abuse and neglect. We agree that it is very important that practitioners are supported in this complex role. Recommendation 1.8.5 relates to supervision of staff, which we recognise is crucial to supporting professional judgement and the wellbeing of professionals.
Esoteric Practitioners Association (EPA)	Full	22	6	'Supporting Practitioners to recognise abuse and neglect'. Although these guidelines may support practitioners and professionals in spotting signs of abuse and neglect what needs to be addressed is the lack of resources and services available to truly hold and support any young person that has experienced abuse and neglect. Currently it is more a band aid approach due to lack of staff, resources and services. Professionals are often constricted by systems having to complete paperwork and targets resulting in less time to work with people. It seems that paperwork has overtaken common sense and good judgment. It has been replaced with a plethora of policies, procedures, workplace codes of conduct and documents that add nothing new to a beleaguered system.	Thank you for your comment. We hope that the recommendations in this guideline will encourage investment in evidence-based services.
Esoteric Practitioners Association (EPA)	Full	30 31 31 31	17 3 9 18	The guidelines make reference to numerous interventions for children, young people and parents. However, in the experience of professionals these are unrealistic and sometimes non-existent due to lack of funding and minimal resources.	Thank you for your comment. We hope that the recommendations in this guideline will encourage investment in evidence-based services.

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Esoteric Practitioners Association (EPA)	Full	34-35	26	'Supervision and support of staff'; Although the draft guidelines acknowledges the importance of supervision, many staff do not receive an adequate level of support and supervision. This is overlooked or staff are allocated an incredibly brief amount of time. This is critical. As aforementioned, staff are our biggest asset. Staff require time, good supervision and support to be able to do their jobs properly. Case loads need to be realistic and reasonable. Recruitment and retention of staff would have longevity if both self-care and health care were included in the ethos of the organisations. Supervision needs to be the cornerstone of a working week with counselling available when needed. The abuse that workers see is often disturbing and needs to be treated accordingly with adequate support for staff to do so.	Thank you for your comment. We agree that supervision is of high importance, as reflected in recommendation 1.8.5.
Esoteric Practitioners Association (EPA)	Short	18	25	We are in absolute agreement with this comment but at the moment our Social Care system is run on a foundation of risk aversion. What does this look like on the ground? Professionals approach their work with a constant sense of anxiety and fear about making mistakes and the repercussions of those. People do not feel safe and supported, so in spite of our best intentions we end up running our work and caseloads with our eyes constantly on our own backs rather than addressing the real needs of our clients. Whilst we approach our work from fear for ourselves and our organisations we are becoming more distant from our purpose to support people and their needs. We are creating dependency on tick boxing and lack of autonomy by abandoning our professional self-direction. Instead we fearfully follow directives. In this environment, we are not responding to clients bespoke needs. There is an irrelevance in our formulaic approach which means that those needing the service are not inspired and supported to take responsibility for themselves. If someone does not feel that their circumstances are being recognized and met they sense that they are just a problem to be fixed in the short-term. For example: in a recent Child Protection Core Group meeting with 11 professionals to 3 clients, the emphasis of the meeting was on record keeping and ensuring our professional directives had been met rather than taking care of and addressing the very real needs of the clients.	Thank you for your comment. The guideline committee were mindful of the importance of supporting practitioner judgement in the complex task of child protection. Recommendation 1.1.13 aims to encourage critical thinking and avoid 'tick box' thinking. Recommendation 1.8.5 also highlights the importance of supervision and support for practitioners.
Esoteric Practitioners Association (EPA)	Short	19	14	It is in everyone's best interests to have a multi disciplinary approach, however therapeutic and collaborative relationships are not being built and nurtured. In our experience, people often do not feel safe to speak up about what is really going on for them; a divisive culture of 'them and us' is perpetuated and nobody feels safe to seek the support they need. 'Them and us' does not just refer to clients versus professionals, it is also within our workplaces and between the different supporting agencies involved. There is a culture that leaves us all isolated and defensively guarding 'our patch' rather than truly working together, which results in demoralization and lack of support and unity for all.	Thank you for your comment. We agree that a multi-disciplinary approach can be difficult to achieve, and hope that these recommendations will support this.
Esoteric Practitioners Association (EPA)	Short	21	13	There is no doubt that all practitioners working with children need to understand how to work with families as a whole but this is not just about training it is about a standard of working conditions that supports, inspires, enables and empowers them to access and implement the training.	Thank you for your comment. We agree that organisational context is very important, and the recommendations in Section 1.8 aim to address this.
Esoteric Practitioners Association (EPA)	Short	General	General	In order to help users overcome any challenges we need to be up front about the risk adverse culture within our system and the impact of this on practise. It is only from this reality check that we will be able to achieve the aims of the NICE guidelines.	Thank you for your comment. We agree that organisational culture will be an important part of implementing the guidelines.
Esoteric Practitioners Association (EPA)	Full	Page 15	Line 21	Practitioner awareness of risk: One of the areas which will have the biggest impact on practice in relation to awareness of risk, and be challenging to implement, is recognising abuse to staff. The reason for this is that abuse of staff who burn out, who leave the profession in large numbers after years of expensive training, who work up to 50-60 hours a	Thank you for your comment. We recognise the importance of supporting staff in the difficult job of safeguarding

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				week just to manage their work loads is an unrecognised and unaccepted abuse. Yet this form of abuse deeply affects how practitioners assess risk and abuse in others. One of the outcomes of staff who are overwhelmed is that we see on ground level that communication is not efficient and effective. We know that it's vital to maintain communication across all professional lines but this is hindered by the overwhelming experiences of staff who feel they are under siege with their workloads and have limited capacity to communicate to other professionals, placing clients at risk of harm. If a system is abusing you, yet this is presented as normal behaviour, are you able then to actually see the abuse between others in front of you? By and large, the answer would be no. If you are numb to or accepting of abuse, your threshold of what is acceptable abuse to another will be significantly and dangerously skewed. *Are professionals capable of addressing and dealing with abuse of their clients if they accept abuse of themselves as normal?* When we allow professionals to be abused through demand of workload that outweighs the available capacity and resources, what messages are we sending to them and to the vulnerable people they are working with? We need meaningful change that resets the culture putting the wellbeing and health of staff as a priority. The restructuring required for these changes is fundamental, but with a long-term view the short term cost increases make absolute sense when we will then be working with a purposeful, healthy and fully functioning work force. At the moment the focus is very much on function above people, getting the job done takes precedent regardless of how that affects the health and wellbeing of the person. It is recognised that this will be a challenge to implement because staff are so inured to the abuse they are experiencing on a daily basis that they don't realise the parameters of the abuse and the impact it is having on their bodies and their mental health. With a foundation of self-care, clients can feel a fundamental support that comes from teams who know their value. Role modelling such an important way of living supports others to be able to say no to abuse. If we are to fully and responsibly address the abuses in our communities and families, then we need to fully and responsibly address the abuses within the work place. We need to first see and accept that abuse in the work place is a prevalent reality, and to understand that this is so because we have collectively normalised it. This begs the question how bad does it have to get before we can see it for what it is and so do something about it?	children. Recommendation 1.8.5 refers to support for staff through supervision.
Esoteric Practitioners Association (EPA)	Full	23	11	The capacity to assess risk and need in relation to child abuse and neglect is hampered by the poor health of staff due to excessive hours and workloads. This report from the Health and Safety Executive makes for sober reading: (http://www.hse.gov.uk/statistics/causdis/stress/stress.pdf). It shows us that Welfare Professionals experience nearly double the rate of work related stress than any other professional group. Workloads being the single biggest cause of stress, depression and anxiety. It raises a very interesting question: why do we as a society allow those charged with addressing and dealing with abuse to experience such levels of stress, anxiety and depression within their place of work? When we are not supporting our health care professionals, how can they deliver effectively to reduce risk? Work absence in the public sector was 8.5 days per employee in 2016. This is 3.3 days higher than in the private sector. Stress and mental ill health are two of the top three reasons for absence within the public sector. Half of the public sector report an increase in stress-related absence and two-thirds an increase in mental health problems (https://www.cipd.co.uk/Images/absence-management_2016-public-sector-summary_tcm18-16580.pdf). In Tracy C Whateron's published article in The New Social Worker entitled *Compassion Fatigue: Being an Ethical Social Worker* she describes compassion fatigue and secondary traumatic stress. The main focus and reference is on Figley 2002; McCann and Pearlman 1990; Meyers and Cornille 2002; Pryce, Shackleford and Pryce 2007 and Valent 2002, who comment on the high incidence of suicide, high turn over rates in employment and high rates of burnout and disruptive symptoms to personal lives resulting from traumatic stress. An example of this is given by one of our managers consulting for the EPA, who reported: *"staff had asked for clinical supervision, numerous times over two years but the senior manager had declined. At the same time the same manager decided all staff needed to go on mandatory training on domestic abuse, motivational interviewing and systemic practice level 1, which added to the stress of not meeting targets. The training was great but as the work is process driven, staff do not have the time to implement the training fully as it feels to them like an impossibility."* Does the problem lie in the short sightedness of current policies and procedures? It seems so, for it is in these policies where the government wants to present themselves as providing training for what they know is needed, yet the employer does not provide the time and resources to actually implement the training on the ground.	Thank you for your comment. We recognise the importance of supporting staff in the difficult job of safeguarding children. Recommendation 1.8.5 refers to support for staff through supervision. In order to ensure that the Guideline considered the most recent evidence, the review protocols specified that no literature would be considered that dated from before 2004. A date cut-off is used to limit the volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal framework for how social services and other agencies deal with issues relating to children. We would therefore be unable to consider for inclusion the studies you have suggested by Figley (2002), McCann and Pearlman (1990), Meyers and Cornille (2002) and Valent (2002). The report by the Health and Safety Executive would not have been considered, as it is not a piece of empirical research into child abuse and neglect. The same is true of the article by Wharton on compassion fatigue.

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				Ultimately, how supportive are we truly being to those who seek help from professionals, when those professionals are experiencing the exact same symptoms of stress and anxiety as those they wish to serve.	
Esoteric Practitioners Association (EPA)	Short	41	12 -21	There is a notable lack of high quality research into effective prevention of abuse. This needs to address the issue of perpetrators and how to support them to recognise their own desire to abuse, thereby intervening at the earliest possible stage. Prevention of abuse is cost effective bearing in mind the financial implications of dealing with its long-term effects. These guidelines fail to address in any significant way the perpetrator or potential perpetrator of abuse and how to identify them and support them prior to them committing an offence. There is an attitude of condemnation present in our society and possibly in our systems. https://wccsj.ac.uk/images/ docs/mccartan_media_and_ paedophilia.pdf The News of the World's 'Name and Shame' campaign was linked to vigilante action (Bell 2002; Thomas 2005; McCartan 2008a), Bell, V. (2002) 'The Vigilant(e) Parent and the Paedophile: The News of the World Campaign 2000 and the Contemporary Governmentality of Child Sexual Abuse', Feminist Theory, 3: 83–102. Thomas, T. (2005) Sex Crime: Sex Offending and Society (2nd edn). Cullompton:Willan Publishing Working proactively is an obvious way to reduce the actual instance of abuse occurring rather than reactively introducing measures after the event. In the West Country, there are examples of programmes for perpetrators of Domestic Abuse through an organisation called SPLITZ: https://www.splitz.org/need-help/perpetrator-programmes.html There are standards offering accreditation for such programmes: http://respect.uk.net/work/work-perpetrators-domestic-violence/ The Lucy Faithfull Foundation - https://www.lucyfaithfull.org.uk/home.htm - appears to be the only organisation to offer programmes or training for potential and actual abusers. However, because of the cost implication it makes it much more difficult for people on low incomes to access. There are very limited offerings through statutory organisations prior to a person being convicted. Even the NSPCC were unable to offer any advice about where a potential perpetrator could go for help. Does a person ever recognise that they have a 'problem' and seek help? A social worker with 25 years of experience working in Child Protection says that only once in that time has a perpetrator come to her and asked for help.	Thank you for your comment. The recommendations on early help interventions in Section 1.5 aim to help parents and carers who are showing early signs of abuse or neglect, often linked to parental stress. In order to ensure that the Guideline considered the most recent evidence, the review protocols specified that no literature would be considered that dated from before 2004. A date cut-off is used to limit the volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal framework for how social services and other agencies deal with issues relating to children. We would therefore be unable to consider for inclusion the study by V Bell. The review protocols also specified that the research used for the Guideline would not include books, which means we would not be able to include the book by T Thomas which you suggested.
Esoteric Practitioners Association (EPA)	Short	General	General	We appreciate the potential of our welfare, education, social and health systems, however we currently fall short of what is required to address the abuse and neglect of children, young people and families. There is systemic abuse and neglect of staff and lack of long-term vision and resources, that puts those we are tasked to serve at further risk of abuse. Until this is addressed, guidelines such as these will be ineffective at bringing about the required changes. Whilst we keep addressing the problems we have in parts, as we do, we will go around in the same circle repeatedly. Those who pay the greatest price for our falling short of what is needed, are those we seek to protect the most. We recommend NICE to review a successful model within a health care system that has taken place in Anchorage Alaska at South Central Foundation regarding an organisational change process known as 'Intentional Whole System Re-design'. This is known as the 'Nuka Model Of Care', a process intended to bring about systematic change, involving all stakeholders at all stages which has proven to be successful for vulnerable communities *and* highly cost effective. https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/intentional-whole-health-system-redesign-Kings-Fund-November-2015.pdf In conclusion the EPA states that this is simply about having people and their well-being central to every decision that is made, and the profound impact such an approach to human resource development can have on the recipients of the service they are tasked with supplying.	Thank you for your comment. We recognise the importance of supporting staff in the difficult job of safeguarding children. Recommendation 1.8.5 refers to support for staff through supervision. As part of developing the guideline, we reviewed evidence in relation to organisational factors supporting professional practice. We did not find any evidence that met our criteria relating to the Nuka model of care.

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Planet Autism via False Allegation Support Organisation (FASO UK)]	Full	General	general	NHS NICE Consultation "Child abuse and neglect" Submission by Planet Autism via FASO (stakeholder) It is with huge concern that this submission is made, following the draft guidance for professionals to look out for so-called 'soft' signs of neglect or abuse. Neglect and abuse are two different scenarios and will necessarily not produce the same 'signs' as one another and therefore lumping potential signs for both into one list is questionable. However, what is of most concern (aside from the worrying culture of seeing abuse at every turn and holding such a high index of suspicion against normal parents), is the apparent lack of differential considerations given to this advice, where disability is not considered as the potential cause. There has to be an 'innocent until proven guilty' approach at the most basic level, to avoid hysteria taking over. Autism spectrum disorder would explain the entire list of the supposed potential signs of abuse or neglect: • "Low self-esteem • Wetting and soiling • Recurrent nightmares • Aggressive behaviour • Withdrawing communication • Habitual body rocking • Indiscriminate contact or affection seeking • Over-friendliness towards strangers • Excessive clinginess • Persistently seeking attention" There may be a variety of invisible disabilities, which in many cases will not be diagnosed, precisely because they are invisible, that could lead to innocent parents being falsely suspected or accused of abuse. These conditions include autism spectrum disorder, ADHD/ADD, Ehlers Danlos syndrome (a connective tissue disorder) which can cause anxiety in the individual. Many 'high-functioning' autistic children are also diagnosed late, or are misdiagnosed (especially females) which leaves their families very vulnerable to having wrongful suspicions raised about the cause for their child's behaviours. There is a concerning trend of autistic and ADHD children being wrongly labelled with attachment disorder, sometimes by unqualified professionals such as social workers or teachers. Such a list will only serve to compound this problem, confirmation bias will be rife among professionals seeking to box-tick. Parent blame is already a huge problem: "Mother Blaming Unfortunately, "mother blaming," an established pattern in the 1950's and 60's, (Bailey, 1994; Bloch, 1997; Caplan & Hall-McCorquodale, 985a, 1985b) is a view that persists in many circles. Such an attitude interferes with the alliance that needs to be established with parents. Even new findings such as etiology, especially as related to children with ADHD (Barkley, 1999), autism and Pervasive Developmental Disorders (PDD) (U.S. Surgeon General, 1999), have not reversed all of those earlier attitudes." http://www.earlychildhoodnews.com/earlychildhood/article_view.aspx?ArticleID=208 "Reflective Inquiry on Professionals' Views on Parents and About Parenting A vital point worth noting is that a significant number of professionals in this study held a quite negative view of parents and their parenting practice. About three-fourths (74.36%) did not see parents as capable, and more than half (60%) disagreed that parents could adequately perform their parental role. This finding, consonant with those of other studies, reveals the popularity of parent-blaming	Thank you for your comments. The guideline committee were mindful of the risks of 'over-identification' of abuse and neglect resulting from encouraging professionals to be alert to signs and symptoms. However, the committee were keen to balance this with the risks to children and young people who are being abuse or neglected if signs are not recognised, particularly given the evidence that a large proportion of children and young people cannot or do not tell people directly. We have added text in to the introduction to the section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders. With regard to stating that signs are alerting features for both abuse and neglect, most of the signs and symptoms were not specifically related to a particular form of abuse or neglect. The purpose of the recommendations is therefore to simply ensure that practitioners take some action in terms of finding more information, or making a referral as appropriate. Where they were, this is stated in the recommendation (for example 1.3.21). The studies you have suggested for inclusion, by Bezdek Summers & Turnbull, and by Williamson Craig & Slinger were both identified during the initial searches in compiling the Guideline, but it was decided not to use them as evidence supporting the recommendations, since the studies did not appear to be specifically about children at risk of or experiencing abuse or neglect, or their families. In order to ensure that the recommendations were based on recent evidence, as there have been significant changes in child safeguarding practices, the review protocols stated that studies from before 2004 would not be considered. A date cut-off is used to limit the volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal

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				among professionals. Bezdek, Summers and Turnbull's study [23] revealed that professionals were both unable to see things from the families' points of view and likely to see the problem as with the family. Another study [24] reported parents' allegations that professionals often attribute children's problems to parental deficits." http://benthamopen.com/contents/pdf/ TOFAMSJ/TOFAMSJ-7-96.pdf Even when children are diagnosed, there are many professionals who are entirely ignorant regarding the condition and will therefore be unable or unwilling to consider other possibilities than abuse or neglect. Professionals are being asked to make judgement calls on matters that may be totally outside their sphere of expertise. There is likely to be an even more heightened 'covering backs' approach by professionals. The system as it is, already harms families incredibly this way, this guidance will only make matters worse. Like any child, an autistic child's behaviour can fluctuate for a variety of reasons. So some autistic behaviours may start where they weren't present before. This is again more likely to be viewed as a potential sign of abuse or neglect purely because it is a new behaviour. It is well known that unwarranted investigations against families causes them trauma, including to the children themselves. Many people never recover from this trauma. https://www.theguardian.com/society/2016/apr/ 15/rise-in-referrals-social-services-trauma-families -child-protection "A huge increase in the number of children being referred to social services has caused "catastrophic" trauma for tens of thousands of families without any corresponding increase in the number of child abuse cases detected, the author of a study has said." "We are now at a situation where up to 5% of all families are now referred for assessment every year," said Dr Lauren Devine, principal investigator of the Economic and Social Research Council-funded study. So, to explain how all the listed behaviours represent well-established typical autism behaviours: Low self-esteem In the research article "Exploring the relationship between measures of self-esteem and psychological adjustment among adolescents with Asperger Syndrome" (S. Williamson, J. Craig & R. Slinger) the measurements for the children with Asperger's as opposed to typically developing children were: AS group (n = 19) TD group (n = 19) Mean (SD) Mean (SD) Negative self-esteem 1.63 -1.92 0.89 -1.52 As you can see, the rates of low self-esteem in autistics are almost double compared to typically developing children. It is well-known, that autistic children suffer low self-esteem due to the nature of their difficulties. Many autistic children are placed in mainstream schools where they suffer sensory difficulties, communication difficulties, socialising difficulties and they are bullied, among other difficulties and all of this impacts their self-esteem negatively. Mainstream teachers have extremely little, often no autism awareness. Wetting and soiling Autism is a neurodevelopmental disorder, which means there are developmental delays. Autistic children may toilet-train late, they may soil or wet themselves, they may smear faeces. They may suddenly start doing it, having not done it before, in reaction to environmental stressors such as in school. Many autistic children also have gastric issues and anecdotally (some research evidence exists for the link), there are many cases of autistics with hypermobility/Ehlers Danlos syndrome (a connective tissue disorder) which is established to cause gastric and bowel issues, as well as urinary issues, through associated features as tethered cord, irritable bladder etc. Many autistics also have allergies which can affect bowel habits. These are invisible disabilities and are therefore often undiagnosed. Autistics often hyperfocus on an activity and do not pay heed to their bodily sensations and this can result in 'holding in' their need for the toilet, which can result in toileting accidents.	framework for how social services and other agencies deal with issues relating to children. We would therefore not be able to consider the studies by Bailey, Bloch, Caplan & Hall-McCorquodale, Barkley and U.S. Surgeon General which you have suggested

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				http://www.disabledliving.co.uk/DISLIV/media/ publicationpdf/ Symposium%20Presentations%202013/ Paediatric/Autism-and-continence.pdf "Social interaction, ASC and continence •May not be socially motivated to wear 'big boy/girl pants' or use the toilet as their peers do •Be less likely to copy others to learn new skills •May not be motivated to please you by weeing or pooing in the right place! • May not mind if they are wet or have soiled themselves •May go to the toilet in inappropriate places" Recurrent Nightmares Autistic children have over-reactive imaginations/graphic worries from atypical perceptions and are prone to phobias, they spend a lot of time on 'high alert' due to sensory issues and anxiety and are much more prone to these difficulties than typically developing children. An anxious child who is prone to phobias will be far more inclined to have nightmares. https://www.iidc.indiana.edu/pages/anxiety- and-autism-spectrum-disorders "This study and others have shown that children with ASD have more severe symptoms of phobias, obsessions, compulsions, motor and vocal tics, and social phobia than other groups of children. Even without an official diagnosis, anxiety is an important factor in the everyday lives of many children and teens with ASD." http://www.autism.org.uk/about/health/child-sleep.aspx "Many children will have disturbed sleep as a result of a number of root causes." http://www.med.monash.edu.au/assets/docs/scs /psychiatry/autism-sleep.pdf "Some children with autism have unusual routines for settling to sleep and may sleep walk and have nightmares more than other children." Aggressive Behaviour Another well-known autistic behaviour, autistic boys are more likely to behave disruptively in school, but both males and females will be aggressive at home, where they release the stress of their school day. ADHD is another factor in aggressive behaviour and over 40% of autistics have co-morbid ADHD. Pathological demand avoidance (PDA) ASD sub-type, which is grossly under-diagnosed globally, brings often the most challenging autistic behaviours of all, as it has the highest anxiety levels of all autism spectrum sub-types. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4160737/ "Aggressive Behavior Problems in Children with Autism Spectrum Disorders: Prevalence and Correlates in a Large Clinical Sample Aggressive behavior problems (ABP) are frequent yet poorly understood in children with Autism Spectrum Disorders (ASD) and are likely to co-vary significantly with comorbid problems." Withdrawing Communication ASD is a communication disorder! Levels of communication may vary according to the child's energy levels, environment, state of health, anxiety levels, sleep, comfort level with those present, sensory issues etc. There can be overlap between ASD and ADHD communication difficulties. Autistics have 'shut-downs' where they become overwhelmed and it may be that they opt to shut-down instead of meltdown because of being in school and feeling inhibited. "People With Autism Withdraw From Others Because Autistic Brain Generates 42% More Information While At Rest" http://www.medicaldaily.com/people-autism-withdraw-others-because-autistic-brain-generates-42-more-information-while-rest-268405 Habitual body rocking	

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				Rocking is a very well-known stereotypic or 'stim' (abbreviation of self-stimulatory) behaviour in ASD. https://www.autism.com/symptoms_self-stim • "Vestibular rocking front to back, rocking side-to-side" Indiscriminate contact or affection seeking/Over-friendliness towards strangers Autistic children are known to have difficulties recognising boundaries. http://tweb-delivery.autism.org.uk/about/behaviour/common-questions/stranger-hugs.aspx "My 14-year-old son does not understand appropriate body contact with different people and will hug strangers in the street. Understanding boundaries and body language can be very difficult for autistic people to understand: I hug my friends in the playground, why can't I hug someone I meet in the street?" Excessive clinginess Many autistic children suffer with anxiety disorders, including separation anxiety. https://www.iidc.indiana.edu/pages/anxiety-and-autism-spectrum-disorders "The prevalence of specific anxiety disorders in youth with ASD were found at the following rates: •Specific Phobia: 30% Obsessive-Compulsive Disorder: 17% •Social Anxiety Disorder/Agoraphobia: 17% •Generalized Anxiety Disorder: 15% •Separation Anxiety Disorder: 9 % •Panic Disorder: 2% " Persistently seeking attention All children have periods of attention-seeking. Autistic children may attention-seek because they are anxious, or uncomfortable in their environment in school. If they have ADHD (either standalone or co-morbid to their autism) their behaviour may be even more likely to be interpreted as attention-seeking. The following article by a teacher, discusses attention-seeking behaviours in autistic children: http://www.autismcomplete.com/single-post/2015/10/11/5-Simple-Steps-for-Ignoring-Attention-Seeking-Behaviors "If you've spent enough time with Autistic children, you've probably experienced all sorts of behaviours. In my five years teaching children on the spectrum, I feel like I've seen it ALL! Crying, spitting, kicking, yelling, cursing, singing, hitting, laughing and even self injurious behaviour." https://www.understood.org/en/learning-attention-issues/child-learning-disabilities/add-adhd/why-some-kids-with-adhd-seek-attention-and-play-class-clown "Why Some Kids With ADHD Seek Attention and Play "Class Clown" • "Kids with ADHD often use attention-seeking behaviours to mask difficulties. • Being the class clown can be a way for kids with ADHD to cope with anxiety." 20 box 1 & 2 Contains a variety of behaviours that could be explained by autistic spectrum disorder, with controlling behaviour towards parents is common in PDA and excessive emotional responses of a variety of types are common in ASD, which may be undiagnosed. Dissociation (21.1.2) Autistics are known to dissociate as part of the condition: "Dissociation in performance of children with ADHD and high-functioning autism on a task of sustained attention" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2000292/	

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				21.1.3 "self-harm eating disorders suicidal behaviours bullying or being bullied." All the above are known autistic behaviours or difficulties. 21.1.7 An autistic child is highly likely to react atypically to a health examination or assessment in a developmentally unusual way by any of those cited behaviours: extreme passivity, resistance or refusal. 21.1.11 What about undiagnosed medical reasons such as autism? 22.1.2 In autism this is a distinct possibility and the child may be as yet undiagnosed. 23.1.1 Behaviours that could easily be present in autism and especially if the sub-type is PDA - and the child may be undiagnosed. 23.1.2 and 47.1 An autistic child may actively reject what are considered typical levels of socialisation despite a parent's best efforts. Especially if the child is undiagnosed the parent will be falsely blamed. 23.1.7 An autistic child will often want their parent present at an assessment precisely because the child has a social communication disorder. Their engagement can be actively impaired by any refusal to allow this and a parent falsely accused when they are advocating for their child at their child's wishes. 23.1.4 – immunisation Immunisation is optional – this should absolutely not be included as a sign of neglect. If a parent failed to meet other healthcare needs, even then immunisation should not be on the list as a sign of neglect. Many autistic children suffer reactions to immunisations and people do a lot more research nowadays about what harmful ingredients are contained in vaccines. Trauma symptoms Exaggerated startle response is very common in autistics who are on hyper alert and have sensory sensitivities. They may also have flashbacks due to negative school experiences that are nothing to do with their family environment. Emotion Skills A hugely unreliable test of an autistic child who struggles to identify emotions. Positivity Many autistic children suffer mental ill-health and present atypically so this is hugely unreliable in their case. Aversiveness The behaviours described could happen in autism, especially PDA. Involvement Hugely unreliable in autistic children, even pointing which is known to sometimes be impaired in autistics is cited. Passivity Not uncommon in autistics especially PDA where part of the profile is passive early years. Language Development Known to be impaired in classic autism! Child Social Competence Known to be impaired in all ASDs!	

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				So this submission is made, to evidence that this list is potentially very dangerous for innocent families of children with invisible disabilities. It encourages professionals to be one-track minded, it's a runaway train and has to be stopped in it's tracks before even more damage is done to families than the immense damage already going on across the UK. Here is a sample of what is meant by that: http://www.hcbgroup.com/site/blog/education_blog/parents-face-new-obstacle-for-sen-support "In recent times, a new tactic has been used by Local Authorities when dealing with perceived to be 'problem parents'; the involvement of Social Services. In practice, this is becoming more commonplace." "...it is becoming more apparent that Social Care Departments across the country are quick to conclude that it is simply 'bad parenting' as opposed to considering the features of the diagnosis." "If however the parents are intent on seeking funding for further support or a specialist ASD placement (via the SEN Tribunal) then this procedure is often used as a means of halting any challenge to the Authority regarding educational issues; a quite shameful tactic. Unfortunately, situations like this are becoming the norm." "As opposed to working collaboratively with the family, many Local Authorities will go on the offensive. Any perceived challenge from parents will be a catalyst for Social Services involvement and a host of issues for them to face, most notably child protection procedures..." Social services referrals are being made against families in retribution and such a list will give professionals open season to do it with further ease. Most professionals know nothing about autism and other clinical and medical conditions, unless they are a doctor. So they simply do not have the expertise to understand what is in front of them. It is flabbergasting frankly that this list will be issued without associated mandatory guidance on ensuring there is no possibility of there being a medical or clinical cause for any of these behaviours. Parents are not the enemy! Children need to be protected from false accusations being made against their parents! Unless there are checks and balances and until free rein being given to anyone with the title of 'professional' is stopped, there will be mistakes, misrepresentations and further harm to families.	
The Fostering Network	short	general	general	The Fostering Network welcomes these guidelines. Question 1 – fostering services will find it a challenge to offer therapeutic interventions to children and young people in their care . Mental health services are inconsistent and foster carers and fostering staff do not always have the opportunity for training around therapeutic interventions . Question 2 – there will be costing implications re services for children in care and mental / therapeutic services- but the investment needs to be made . Question 3 – very often guidelines like these are really helpful to practise – but they do not get promoted or publicised – it would be really important that that awareness workshops , training , recognition from national bodies was given to the guidelines .	Thank you for your comment. The guideline committee acknowledge the financial contrainsts in many parts of the sector, and considered carefully the resource impact of the recommendations, including making use of economic evidence and economic modelling data, and the practice experience of committee members regarding currently available provision. Although it was acknowledged that many of the recommendations may have some resource implications, the committee thought it was important to make recommendations in order to highlight good practice as identified in the research evidence. The majority of interventions recommendations are worded as 'consider' recommendations, meaning that practitioners should think about providing the intervention, rather than that they must offer it. Thank you for your comments regarding implementation, which we will share with colleagues in the implementation team.
Faculty of Sexual and Reproductive Healthcare	Full	38		NICE should favour duty to act over mandatory reporting to achieve better overall outcomes for children. Any research conducted should encompass this view and not focus solely on mandatory reporting. FSRH holds this view as mandatory reporting risks focussing professional attentions on the act of reporting, undermining a holistic, individualised and whole system approach to child protection and safeguarding. Mandatory reporting could have an adverse impact on child protection in that abusive and coercive relationships could	Thank you for your comment. We have removed the research recommendation on mandatory reporting in light of ongoing government consultation on this issue.

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				remain hidden as young people feel they have no safe space in which to talk in confidence with trusted healthcare professionals.	
Faculty of Sexual and Reproductive Healthcare	Full	512-513		Further to our advocacy for a duty to act, this reporting duty should be applied for FGM as well. The faculty makes this comment in relation to the research question posed about effective ways of tackling sexual abuse (and specifically FGM). Some of our members have reported that mandatory reporting has resulted in a diversion of resources away from the provision of support and services for those at risk of harm or already harmed by FGM. Instead, resources are being driven towards assessment and investigation of referrals that carry less risk, including young girls with genital piercings or tattoos, meaning that those with increased risk or who have experienced significant harm from FGM may not receive adequate care and support.	Thank you for your comment. Recommendation 1.3.8 now makes reference to the Home Office guidance on mandatory reporting of female genital mutilation.
Faculty of Sexual and Reproductive Healthcare	Full	13	1.1.13	With regards to coordinating work and sharing information between practitioners, hundreds of thousands of young people attend SRH services each year and have frank and open discussions about their relationships, often making disclosures to healthcare professionals who are then able to make assessments as to their risk of harm. Given this, SRH should be treated appropriately, and accountability placed on individual SRH professionals and SRH service providers in relation to recognising, assessing and responding to abuse and neglect of children and young people. In addition, it is the Faculty's belief that as well as seeing SRH services as above, youth services and drug and alcohol treatment services should be included in the defined activities to which reporting abuse should apply.	Thank you for your comment. Health professionals are one of the key audiences for this guideline, as well as for the guidance on Information sharing which is now referenced in recommendation 1.1.12. There is currently no mandatory duty to report abuse and neglect, although Government advice such as 'What to do if you're worried a child is being abused' highlights that it is good practice to do so.
Faculty of Sexual and Reproductive Healthcare	Full	General	General	Accountability for reporting should rest at an organisational level as individual failings can be the result of wider organisational issues and failings and if reporting is breached; existing practitioner and organisation specific-sanctions should apply.	Thank you for your comment. There is currently no mandatory duty to report abuse and neglect, although Government advice such as 'What to do if you're worried a child is being abused' highlights that it is good practice to do so.
General Medical Council	Full version	general		We are pleased to note that the broad principles underpinning the draft guideline are in line with our guidance on *Protecting children and young people: doctors' responsibilities* and *0-18 years: guidance for all doctors*. In particular, we welcome the focus on an individualised approach that takes account of each child or young person's specific needs (1.3.6), and the importance of communicating to families openly about child abuse (1.3.7).	Thank you for your comment, and for your support for the guideline.
General Medical Council	Full version	11	1.1.5	While we recognise and appreciate the spirit of this guideline, and the focus on consent for touching a child or young person, we are concerned that it is incomplete and could be misleading. There is a section on *making decisions* in our *0-18 years* guidance, which covers issues of consent for investigation or treatment, and paragraphs 61-70 of the guidance *Protecting children and young people* give specific guidance on child protection examinations. You may find these sections helpful to refer to. Our first concern is that there could be circumstances in which it would be appropriate to seek consent for something that does not involve touching a child or young person. For example an examination could be visual or based on talking to the patient (as in the case of psychiatric assessment) or may involve taking measurements or carrying out tests without touching a patient (such as testing a urine sample). By limiting this guideline to circumstances in which it is necessary to touch a child or young person, it fails to cover other circumstances in which it would be necessary and appropriate to seek consent for a particular action. Secondly, while we are in agreement that practitioners should seek consent from children and young people who have the capacity to consent, we feel that the wording of the guideline is not precise enough and is incomplete. When assessing capacity to consent, young people aged 16 and 17 can be presumed to have the capacity to consent and as you say, those aged under 16 may have the capacity to consent (i.e. they may be Gillick competent). However this does not mean that every 16 and 17 year old does in fact have the capacity to consent, which is what the guideline suggests. The guideline doesn't address the issue of seeking consent to examine children or young people who lack the capacity to consent. This could imply that consent in not necessary in these circumstances, which is not the case. In paragraphs 27 and 31 of our 0-18 guidance we say that doctors should ask for parental consent when a child or young person lacks the capacity to consent, and that investigations and treatment can be carried out on this basis. By 'parents' we are referring to those with parental responsibility for the child or young person in question.	Thank you for your comment. This recommendation aimed to focus on getting consent before touching a young person (rather than issues of consent in general) as children and young people who have been abused may have particular difficulties with being touched. Recommendation 1.1.5 now makes reference to the General Medical Council's 0-18 years: guidance for all doctors. It also states that the provisions of the Mental Capacity Act 2005 should be followed.

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				Without consent from the patient or those with parental responsibility, doctors may only treat or examine children or young people by order of the court or under specific legislation such as mental health legislation (NB there are differences in legislation across the UK relating to 16 and 17 years olds and doctors must follow the legal framework in the jurisdiction in which they practice). Even where children and young people are not able to make decisions on their own, doctors should involve them as much as possible in decisions about their own care. There is further guidance on these issues, including what to do when there is disagreement between doctors, children and young people, and their parents, in paragraphs 22-33 of *0-18 years*.	
General Medical Council	Full version	13	1.1.13	We recognise the importance of practitioners working closely together so that children, young people, parents and carers do not need to give the same information repeatedly, however doctors will need to make sure that they follow the principles within our guidance on *Protecting children and young people* (see paragraphs 28-51, which refer to confidentiality and sharing information).	Thank you for your comment. This recommendation (now 1.1.12) now makes reference to the Department for Education's multi-agency advice on information sharing.
General Medical Council	Full version	22	1.2.46	The draft guideline mentions ensuring all practitioners working in primary care can recognise and respond to child abuse and neglect, and one way to achieve this includes training newly qualified doctors in risk factors for abuse and neglect. As the professional regulator, we have set out general duties on all doctors to keep their knowledge and skills up to date (paragraph 8 of our core guidance *Good medical practice*), and a specific duty to have a working knowledge of local procedures for protecting children and young people in their area (paragraph 4 of *Protecting children and young people*). You might want to consider whether a reference to these professional obligations would strengthen this guideline. It might also be helpful to recommend this training to all doctors as opposed to only those who are newly qualified. We also say in *Outcomes for Graduates* and *Outcomes for Trainee Doctors* that doctors will be able to recognise the signs of child abuse and act appropriately.	Thank you for your comment. Recommendation 1.3.10 has been amended to align with the standards set out in the intercollegiate training document.
General Medical Council	Full version	27	1.5.1	We are supportive of this draft guideline. In paragraph 42 of our *Protecting children and young people* guidance we say that doctors should follow up their concerns and escalate if necessary.	Thank you for your comment. The recommendation you refer to has been removed following consultation feedback, as it duplicates what is in Working Together.
General Medical Council	Full version	27	1.5.2	The draft guideline states practitioners working with families where a child is involved in statutory child protection processes should take part in case conferences and meetings about the child. We say in paragraphs 26-27 of our guidance on *Protecting children and young people* that doctors must cooperate fully when asked to participate in child protection procedures and must try to attend meetings where possible. You might want to consider whether a reference to these professional obligations for doctors would strengthen the guideline.	Thank you for your comment. The recommendation you refer to has been removed following consultation feedback, as it duplicates what is in Working Together 2015.
General Medical Council	Full version	34	1.7.4	We are supportive of the draft guideline's intention to encourage agencies to agree ways to share information when it is in a child or young person's best interests. In our guidance on *Protecting children and young people* we say doctors must share information promptly if they have concerns that a child is at risk (paragraphs 32-33). When sharing information, doctors must ensure that they follow the principles in our guidance. Paragraphs 32 to 38 of *Protecting children and young people* explain doctors' responsibilities when sharing information about children who may be at risk of harm including the limited circumstances in which it may be appropriate to this this without consent.). When developing or following local processes doctors must ensure that they are do so in line with our guidance. We recognise that giving agreed database access to staff in other agencies is an example rather than a recommendation, and also that it may in some circumstances be appropriate, but it is important to note that we expect doctors to use the principles in the guidance to make judgements about how much information is appropriate to share in any particular case, as well as when, how and with whom they should share it. Information should not be shared uncritically or as a matter of course, and we expect doctors to be able to justify their decisions and actions. (*Good medical practice*).	Thank you for you comment. The recommendation you refer to has been removed following consultation feedback, as it duplicates what is in Working Together 2015.

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Great Ormond Street Hospital for Children	Short	33	9	We are of the view that the definition of sexual abuse as 'forcing or enticing' a child is not broad enough. Many of the children we see have been engaged in sexual activity from such a young age that no one has needed to force or entice them, we have also worked with children who were exposed to extreme pornography constantly in the background. Our concern is that the definition used in the guideline colludes with the cognitive distortions of both perpetrators and victims that their experiences or actions were not abusive.	Thank you for your comment. We have used the definition of sexual abuse given in Working Together 2015 statutory guidance.
Great Ormond Street Hospital for Children]	Short	general		Disappointing that EMDR is not included as an effective treatment for trauma symptoms stemming from abusive experiences and for building resilience and strengthening the attachment relationship.	Thank you for your comment. The evidence we found in relation to EMDR did not meet our criteria and was not included. Two studies were screened on full text, one (Farkas et al. 2010) was excluded because the majority of children and young people in the study had not experienced child abuse or neglect (but were traumatised for other reasons). The second (Jarero et al. 2013) was excluded because the study was undertaken in Colombia, which was not one of the included countries in the review protocol.
Great Ormond Street Hospital for Children	Short	general		More emphasis on screening measures for complex trauma symptoms. Briere's Trauma Symptom Checklist for Children and the parent rated version for younger children. Scheeringa's manual for identifying trauma symptoms in the under 5s is also a very helpful tool. These should be used with a comprehensive clinical interview of trauma symptoms and coping strategies.	Thank you for your comment. We searched for evidence on tools to support recognition and assessment, but did not find any evidence that was sufficiently strong to support a recommendation.
Great Ormond Street Hospital for Children	short	27	3	We were concerned that this recommendation might lead clinicians to be too pessimistic when presenting the treatment model to young people who are already anxious and avoidant. We usually say symptoms sometimes get worse before they better and parts of the work are difficult however we can adjust the pace and the content to meet individual needs. We let the young person have a lot of control over the intervention and spend lots of time strengthening positive experiences as well as reprocessing traumatic ones.	Thank you for your comment. This recommendation (now 1.7.17) has been amended in line with your feedback, and reference to explaining that other young people not finding the intervention helpful has been removed.
Independent Children's Home Association	Short	General	general	The ICHA is the policy and practice representative organisation for independent children's homes. We note that residential child care options are yet not included in this guideline, whereas other placement options are stated. Residential placements are some of the places where our current thinking and practice regarding abuse and neglect was developed. Children's homes are of many type, from residential special schools open 52 weeks a year to specialist mental health facilities. Not to include this sector could be to deny a young person access to the right placement. NICE documents are frequently cited in local authority policies and so need to be as inclusive and comprehensive as possible. Most homes are ordinary sized; most are for fewer than four children, in ordinary streets. Some foster homes are bigger than children's homes. For many experienced social workers and commissioners, children's homes are first choice, as the know that the highly skilled and experienced, integrated personnel required are readily available. Substantial education alongside psychiatric, psychological and therapy is accessed swiftly through residential placement, the fragmentation and delays elsewhere are not encountered. The DfE Quality Standards and Ofsted inspection framework for children's homes have the making of meaningful relationships, an essential aspect of responding to neglect, as an expectation. Warm, nurturing care (Quality Standard Looked after child and young people QS 31 #1) is exactly what is required and delivered in children's homes today from specialist and dedicated services. There are numerous residential references that can be included in the section Development Resources. With regard to neglect, may we also draw your attention our increasing experience of the systemic failure of local authorities to meet Quality statement 3: Stability and quality of placements (Quality Standard Looked after child and young people QS 31) specifically:-	Thank you for your comment. There is an existing NICE guideline on services to support the health and wellbeing of looked after children, which includes recommendations relating to residential care. Our recommendations therefore aimed to focus on interventions rather than therapeutic placements. The evidence we reviewed included some inteventions delivered 'via' a foster carer or adoptive parent. Interventions provided directly to children and young people (for example trauma-focused CBT) could still be provided to children and young people in residential settings.

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				a) Evidence of a strategy to commission a diverse range of placements for looked-after children and young people, which includes arrangements for considering sibling co-placement.	
Institute of Health Visiting	short	4	13	It would be useful to have some ideas on how to identify abuse /neglect in preverbal children – more information on what behaviour could be seen and how to link that to the abuse/neglect (extended version of Box 1 pg 10)	The section on alerting features (see Section 1.3) is intended to give a series of non-verbal indicators of abuse and neglect, including behaviours that may be displayed by children and young people with communication difficulties.
Institute of Health Visiting	short	5	28	In practice, I have not seen reports from health shared with the child/young person	Thank you for your comment. The guideline committee recognised that this would entail a change in practice for some professionals. This recommendation was based on evidence from the children and young people's expert reference group.
Institute of Health Visiting	short	7	9	Analysis needs to be emphasized as this is always missing from referrals, reports and records and practitioners need to clearly identify what the information means for the child in that situation and what impact this has. Practitioners need to move away from just telling a story.	Thank you for your comment. Recommendation 1.4.7 refers to analysis of information.
Institute of Health Visiting	short	8	23	Would be useful to mention the importance of documenting what the child says using their words	Thank you for your comment. Recommendation 1.1.6 makes reference to using children's own words in documentation wherever possible.
Institute of Health Visiting	short	10	6 & 8	These 2 boxes are really useful	Thank you for your comment. This recommendation has now been split in to three recommendations for clarity (1.3.12, 1.3.13, 1.3.14).
Institute of Health Visiting	short	14	11	Add in concerns if child appears over-compliant	Thank you for your comment. Recommendation 1.3.13 makes reference to children 'demonstrating excessively 'good' behaviour to prevent parental or carer disapproval'.
Institute of Health Visiting	short	15	24	This is better expressed as ''children are not brought for their appointments' rather that did not attend.	Thank you for your comment. Thank you for your comment. This recommendation (now 1.3.42) has been amended to refer to parents bringing their children to appointments.
Institute of Health Visiting	short	16	17	Would be useful to know what specific questionnaires are being referred to here.	Thank you for your comment. Reference to screening questionnaires has been removed from this recommendation (1.3.10).
Institute of Health Visiting	short	21	18	Add in the importance of all involved agencies liaising and sharing relevant information	Thank you for your comment. Recommendation 1.1.12 refers to practitioners co-ordinating their work with those in other agencies.
Kent County Council - KCC	Short	General	General	KCC is pleased to see that this guidance is aiming to instil a sense of collective ownership and responsibility for maintaining the safety and protection of children across all partner agencies with statutory obligations in this arena. However, we wish to emphasise that professionals working in statutory child protection and safeguarding already make daily decisions about suspected or know incidents of child abuse and neglect, and there are legal requirements already in place to ensure that practitioners and organisations who work with children, young people and their families provide those children with adequate levels of protection, support and actively promote their wellbeing. That said, we do recognise this could be a useful tool to aid a better collective understanding of these issues and facilitate more joined-up partnership working. We are also pleased to see that the guidance reinforces the importance of sharing information between agencies in the interests of safeguarding vulnerable children and young people. We are, however, concerned that directing all professionals to report any concerns in relation to known or suspected incidents of abuse or neglect to social care may lead to a significant increase in the number of referrals local authorities receive, potentially causing notable resourcing and capacity issues. By extension, in order to ensure that as many referrals as possible that are made into social care are appropriate, the guidance should emphasise that all agencies with statutory responsibilities relating to safeguarding should have their own internal safeguarding and protection leads, to which the organisation's staff and managers can turn to for advice, guidance and consultation. This should help to reduce the likelihood of all concerns being escalated directly into social care.	Thank you for your comment. We recognise that there is a wealth of knowledge, and legal and statutory duties in this area. Following consultation feedback we have cross-referred to existing guidance more explicitly throughout the document. The recommendations relating to recognition are intended to provide more detailed information on alerting features of abuse and neglect. However, we have added more detail in to the introduction to this section regarding what action should be taken and at what point a referral to children's social care should be made. This text also makes clear that practitioners should seek advice from their internal safeguarding lead in the first instance.

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Kent County Council - KCC	Short	General	General	KCC feels there are likely to be some notable cost implications as a result of a potential upturn in the volume of referrals into social care. For instance, an increase in avoidable/unnecessary referrals is likely to lead to an aligned increase in the numbers of children becoming Looked After and requiring accommodation in foster or residential care. Conversely, a high proportion of these contacts/referrals may be inappropriate i.e. they may not meet the threshold for intervention by specialist child protection services, as a result of unfounded anxieties around the identification and reporting of risk by partner agencies. The resource/intervention costs associated with this may place a significant additional burden on local authorities. Furthermore, these increases would come as Government is looking to increase the support local authorities provide to care leavers up until the age of 25 which is going to lead to increased demand for, and costs sustained by, local authority services. These changes, taken together, would lead to unsustainable additional pressures being wrought upon local authorities - whilst the funding of local authority provision is simultaneously being severely curtailed. We would therefore like to see more explicit reference to the use of early help and preventative services and details about the roles they play in assisting families prior to their escalation into specialist services in the guidance. This will help to ensure that partner agencies are clear about the need to offer the right help to vulnerable children young people and families at the earliest opportunity to achieve the best long term outcomes. There is an additional risk that enacting this guidance may have potential commissioning implications for public agencies, as many local authorities currently commission family support services from third sectors organisations. This needs to be considered prior to publication. Finally, there are likely to be training costs incurred – in particular by Local Safeguarding Children's Boards – to ensure multi-agency staff are familiar with the new requirements and can enact their duties effectively.	Thank you for your comment. We have added explanatory text in to the introduction to this section about the difference between 'consider' and 'suspect' and the different actions associated with each. We have made it clearer that a possible outcome could be an early help assessment, and that only 'suspect' recommendations should immediately lead to a referral to children's social care. Section 1.5 includes a series of recommendations relating to effective interventions at the early help stage. This could include services commissioned from the third sector. With regard to training costs, the guideline committee considered resource impact carefully, and considered the recommendations to be aspirational but achievable.
Kent County Council - KCC	Short	Ge neral	General	Additional funding from central Government, aligned to and covering any increase in demand for local authority social care services, would be required to overcome the challenges we are likely to face in order to implement this guidance. Examples of other local authority areas which have successfully implemented the guidance across partner agencies would also be useful. However, it must be recognised that implementing these changes across geographically large and diverse areas is likely to be more challenging than addressing changes at a more local level.	Thank you for your comment. The guideline committee considered carefully the resource impact of the recommendations, and considered them to be aspirational but achievable. Thank you for your thoughts relating to how the guideline could be implemented, which we will share with implementation colleagues.
Lloyds TSB Foundation for Scotland	Full	General	General	I recognise that the guidance will not apply in Scotland, however was keen to flag a recent piece of action research we published that may be helpful in relation to listening to vulnerable children and young people. Key learning from *Everyone Has a Story* (https://www.ltsbfoundationforscotland.org.uk/wp-content/uploads/2015/10/Everyone-Has-a-Story-Overview-Report-1.pdf - further detailed components available at https://www.ltsbfoundationforscotland.org.uk/grant-programmes/partnership-drugs-initiative/#addressing-thematic-gaps) includes: • Reinforces the importance of children's rights and that children and young people have the right to be involved in their care plans. Guidance on approaches to listening and helping them understand their rights is included in Component 1. • Similarly in terms of working with children and young people, *Everyone Has a Story* provides resources and guidance developed by practitioners to help support active listening, safe and supportive space and how to record and analysis experiences and feelings again included in Component 1. • Telling about abuse and neglect the stories, experiences and feelings shared within *Everyone Has a Story* provides stories and views shared by children and young people and could give some real examples to support the illustrations provided in the guidance. • Recommendations and suggestions for working on support and supervision and how to use this effectively to discuss and explore experiences and stories shared by children and young people and is included in Component 1.	Thank you for your comment. This piece of research was not identified by our literature search. Recommendations 1.1.1 to 1.1.9 relate to ways of working with children and young people.

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London Fire Brigade	Short	9	21	LFB welcome the opportunity to comment on NICE Child abuse and neglect guideline. We are concerned that 'awareness of risk', despite being one of the areas with the greatest impact on practice, it can be challenging to implement. This is because professionals/ practitioners may not be equipped with the necessary knowledge/tools to assess risk/behaviour comprehensively; for instance when faced with children/young people with fire setting behaviour. There is evidence to suggest that there can be a correlation between children/young people with such behaviour and emotional and physical stress. In our experience, there have been instances when opportunities to identify the significance of children's behaviour and address the risk were missed by practitioners. As such, there is need for a better defined (assessment) framework within which professionals/ practitioners can operate.	Thank you for your comment. The framework for assessment is set out in Working Together 2015, which this guideline makes reference to. We did not find any evidence in relation to fire setting behaviours.
London Fire Brigade	Short	10	6 & 8	LFB Juvenile Fire Setter Intervention Scheme's work with children and young people who display fire setting behaviour has highlighted that fire setting is a powerful form of communication and can often be a symptom of underlying emotional or physical stress. Fire is used to express feelings of anger, fear or frustration or to bring attention to a situation a child/young person is unhappy with. These situations can include abuse and neglect. We would therefore recommend that fire setting is added to 'Example of behaviour and emotional states' and 'Example of emotional responses' sections to raise awareness among practitioners.	Thank you for your comment. This recommendation is adopted from the NICE guideline on child maltreatment. The behaviours and emotional states referenced in this recommendation are based on the evidence reviewed as part of developing that guideline, and the professional experience of the guideline committee.
London Fire Brigade	Short	11	10	As above	Thank you for your comment. The framework for assessment is set out in Working Together 2015, which this guideline makes reference to. We did not find any evidence in relation to fire setting behaviours.
Lancashire Teaching Hospitals Foundation Trust	Full	General	General	Please find below the response to the request for feedback on the Guidelines for child abuse and neglect. The guidelines have been looked at by Dr Ruth O'Connor, Named Doctor for Safeguarding Dr Dhia Mahmood, Designated Doctor for Safeguarding and Deborah Gibbons, Acting Lead Nurse for Safeguarding for Lancashire Teaching NHS Trust. Obviously we appreciate that a lot of time and effort has gone into drawing up this guideline but unfortunately this makes it rather difficult and unwieldy to navigate around. There is a large amount of information which makes it rather difficult to read and digest and we feel it would be better if the guideline could be more appropriately divided into guidelines appropriate for the acute medical services, the primary care services e.g. health visitors, education and social care rather than trying to bind these all together. It would be very difficult for one Trust to show compliance with the guidelines in their current state as a lot of the guidelines is in relation to intervention from social care, health visitors, child psychology / psychiatry which are not part of our Trust. On the whole in Lancashire Teaching Hospital NHS Foundation Trust it is the acute Paediatricians who assess the children who are referred with signs of physical abuse although we appreciate that this is done by Community Paediatrician elsewhere. It would probably be more helpful to have guidelines around the type of injury that would be of concern. There is a helpful section around the Children's Act and the different section i.e. Section 17 Section 20 Section 31 and Section 47. We think it would be helpful if there were more visual pathways or flowcharts on the correct approach involving the multi-agency teams. It is helpful to be given the definitions for concern and suspicion and what to do about these two areas, and obviously we approve of the guideline including CSE, Forced Marriage and FGM. Overall it would be better if the guideline could be broken down into areas for specific agencies as it would then be easier to check compliance against these guidelines. It is disappointing to see that there is no evidence of Paediatricians having been included in the draft document committee and we wonder if this is one of the reasons why the guidelines seem very heavy on the social care aspect rather than the medical.	Thank you for your comment. There is a shorter version of the guideline (54 pages) which is the version NICE would expect practitioners to refer to. The longer version provides details of all the evidence reviewed for those wishing to know more. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance. There is a separate NICE guideline on 'When to suspect child maltreatment' which refers to clinical indicators, including injuries and signs of physical abuse. We have included specific reference to this guideline in the introduction. We have not included visual flowcharts relating to different activities under Section 17 and so on, as these are provided in Working Together 2015.
Luton Clinical Commissioning Group	Short	9	Line 3	We recommend that the guidance includes consideration to parents with refugee status , who are not aware of the system and could be deemed to abuse and neglect their children Suggestive bullet point: " Experiencing social changes due to transition (move from a different culture)"	Thank you for your comment. Reference to refugee status has been added to recommendation 1.1.10.
Luton Clinical Commissioning Group	short	"	21	Add as1.2.12: Recognising when a child or young person suffering harm through unmet needs but may not meet significant harm threshold (accumulative harm)	Thank you for your comment. This is covered in the definition of neglect.
Luton Clinical Commissioning Group	short	10	6 (box)	Persistent lying Stealing and constantly asking for food in school	Thank you for your comment. Recommendation 1.3.23 makes reference to hoarding food. We did not find any evidence in relation to lying.
Luton Clinical Commissioning Group	short	14	24	Add before 25 : Constant /persistent change of address – Transient families	Thank you for your comment. These recommendations are adopted from the NICE guideline on child maltreatment and are based on the evidence reviewed by

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					that guideline committee.
Luton Clinical Commissioning Group	short	16	1.2.45	Under No 8 : Potential abuse if parent repeatedly presents a child to clinician or Emergency department. It will be useful to put a number to the number of presentation with same complaint or varying ones, gives practitioners clarity as well as their own assessment and observation.	Thank you for your comment. These recommendations are adopted from the NICE guideline on child maltreatment and are based on the evidence reviewed by that guideline committee.
Luton Clinical Commissioning Group	short	17	17	Please correct spelling of "professionals"	Thank you for your comment. This has been amended.
National association for People Abused in Childhood (NAPAC)	Short	General	General	This is an excellent document and shows evidence of having learned from current best practice in responding to the trauma of childhood abuse of all types and of neglect. NAPAC is set up to support recovery among adults who suffered childhood abuse and neglect. We know many people do not recognise the trauma as abuse until years or decades into adulthood, NAPAC has developed ways of working with such people. These lessons may be of use in working with young people close to age 18 who often do not think of themselves as children.	Thank you for your comment.
National association for People Abused in Childhood (NAPAC)	Short	11	1 to 26	The integrated approach which includes understanding of the impact of an absence of early years secure attachment will greatly assist recovery. A psycho-educational approach can assist in this area; young people may have no bench mark of what is a normal or acceptable childhood experience.	Thank you for your comment. Recommendations 1.7.4, 1.7.5, 1.7.8 and 1.79 refer to attachment-based interventions.
National association for People Abused in Childhood (NAPAC)	Short	16	9 to 18	This is a very good suggestion but could include training of more experienced practitioners who have not been aware of this approach previously. In our work we aware that some parents who struggle to cope have been the victims of abuse and/or neglect in their own childhood so do not have a good model of parenting and need support for their own recovery.	Thank you for your comment. These recommendations relate primarily to training practitioners to recognise abuse and neglect. However, as you suggest we agree it is important that practitioners recognise that many parents have experienced abuse or neglect in their own childhood. We have made reference to this in relation to assessment (recommendation 1.4.4) and the content of home visiting interventions (recommendations 1.5.13 to 1.5.16). This assumption also underlies a number of the interventions offered, including home visiting, early help and therapeutic itnerventions for parents.
National association for People Abused in Childhood (NAPAC)	Short	20	1 to 20	As in previous comment.	Thank you for your comment. As noted above, an underlying premise of many of the interventions recommended is to support parents who may have had poor parenting experiencing themselves in terms of learning parenting skills and modelling parenting behaviours.
National association for People Abused in Childhood (NAPAC)	Short	23	13 to 15	This is very important, there is no 'one size fits all' intervention.	Thank you for your comment. We have added a similar recommendation in to the section on early help.
National association for People Abused in Childhood (NAPAC)	Short	27	1 to 25	We have heard from many adults who struggle with PTSD that psychoanalytic approaches can work but tend to be relatively slow. We find a more psycho-educational approach is more effective. This needs to be delivered by trauma-informed practitioners. For more detail on this approach see Quadara A. and Hunter C. (2016) *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper* Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, Commonwealth of Australia.	Thank you for your comment, and for suggesting the inclusion of the discussion paper by Quadara and Hunter. We would not be able to include this in the literature referenced in the Guideline, as it does not appear to concern a piece of empirical research, and the recommendations of the Guideline are wholly informed by research evidence.
The National Autistic Society	Full	General	General	Concerns have been raised in the autism community because the guideline includes a checklist for identifying potential abuse or neglect, which looks like a potential checklist for signs of autism (more below). There is a long history within the autism community of parents being blamed for their child's behaviour. While attitudes are much better now than they were in the past, parents still regularly contact us to tell us that professionals do not listen to their concerns. We also hear that because of a lack of understanding of autism across public services, combined with the focus on safeguarding within the social care profession, children's social workers may sometimes see potential signs of abuse rather than identifying that they may be seeing signs of autism. It is also important to note that recent surveys indicate that people are waiting years for an autism diagnosis. On average, a survey by City University and Goldsmiths University found that the wait for children was over three and a	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders.

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				half years (http://www.autismdiagnosis.info/0). Therefore it is very likely that social workers will come across undiagnosed children on the spectrum and should be made aware that this might be the case as part of the guideline. More training needs to be made available for social workers to help them better identify autism and understand where for example the lack of ability to understand and recognise emotions or outbursts that look like tantrums in a school aged child might actually be signs of autism rather than a sign of abuse or neglect. Training on autism must become mandatory for all social workers.	
The National Autistic Society	Full	General	General	We understand that research has shown that disabled children are more likely to be abused than non-disabled children, (although interestingly the evidence that the panel looked at, also showed that autism was not associated with a higher risk of abuse). However, given the communication difficulties experienced by children on the autism spectrum, it is important to note that it may be harder to identify abuse of a child on the spectrum. This demonstrates further the importance of training for social workers in autism so that they can identify the differences between signs of autism and abuse. How to better identify signs of abuse among children on the spectrum is also an area for potential research.	Thank you for your comment. The guideline committee recognised the difficulty of identifying abuse and neglect within the context of children on the autism spectrum. Recommendation 1.4.6 suggests that practitioners who are assessing abuse and neglect should have access to specialists with knowledge about neurodevelopmental disorders.
The National Autistic Society	Full	General	General	Given the specific needs of autistic people and their difficulties with communication and social imagination, practitioners will need to consider throughout how they might adapt their communication and any therapies they offer to meet the specific needs of autistic parents or autistic children. How to support a child on the spectrum who has been abused is an area that could be considered for further research.	Thank you for your comment. Recommendations 1.1.2 and 1.1.11 now make reference to meeting the communication needs of children and young people and parents respectively.
The National Autistic Society	Full	10	1.1.2	Given the communication difficulties and difficulties with social interaction that are inherent in autism, we believe that autism should be included as an example of a disability that requires a social worker to use a different communication style. Under this section, it might also be useful to give other examples of alternative communication that children with differing needs may use such as PECS or Makaton.	Thank you for your comment. Recommendation 1.1.2 now makes specific reference to neurodevelopmental disorders and alternative methods of communication.
The National Autistic Society	Full	10-11	1.1.1- 1.1.11	We believe that at the end of this section, professionals should be advised to bring in specialists in a particular disability area, as required to make sure that communication is effective. Some children on the autism spectrum have very complex needs and will need specialist workers to communicate effectively with professionals, especially where professionals are unknown to them. It is also important for social workers to understand that autistic children have a 'spikey' profile and even when seemingly articulate, they may not understand fully what is being asked of them or the social meaning behind the questions asked. Autistic children can often be eager to please and may answer in the way they think a professional wants them to answer, particularly where they don't understand the social meaning behind questions.	Thank you for your comment. Recommendation 1.4.6 suggests that practitioners who are assessing abuse and neglect should have access to specialists with knowledge about neurodevelopmental disorders.
The National Autistic Society	Full	14	1.2.7	We propose an additional sentence on the end of this para, which says 'Also note that for some disabilities, such as autism signs of abuse may overlap with behaviours relating to a disability. Where this may be the case social workers should consider the need for a developmental history to be taken.'	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes.
The National Autistic Society	Full	16	Boxes 1 & 2	We ask that the Guideline Development Group look carefully at these boxes and compare them to the 'signs and symptoms of possible autism' tabled in CG128. The 'signs and symptoms of autism' are much more comprehensive and descriptive, but it is clear to see that unless a social worker has a good understanding of autism, they could easily see difficulties with communication, extremes of emotional reactivity, body rocking or excessive insistence of following own agenda (described in CG128) as 'withdrawal of communication' or a sign of 'low self-esteem', 'habitual body rocking' and 'coercive controlling behaviour'.	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders.
The National Autistic Society	Full	25	1.3.10	We very much welcome this paragraph, which says: *Organisations should ensure that practitioners conducting assessment in relation to abuse or neglect of disabled children or young people can access a specialist with knowledge about those children and young people's specific needs and impairments.* This is important for children on the autism spectrum both to ensure that those who are being abused or neglected are	Thank you for your comment, and for your support for this recommendation. We have also added text in to the introduction to the section on alerting features to make clear that many of the alerting features can be

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				being properly identified and supported and to ensure that autistic young people aren't being wrongfully identified as being abused. We would ask that this point is stressed and highlighted in other parts of the guideline and in the communications being sent to social workers about this guideline.	similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	Cover sheet		The guidance states it is for health, social care, education and police. Given that extensive statutory guidance exists for education and the police, we think it would be helpful to state explicitly from the start that education staff and police may find elements of the guidance useful additional information but restate need to follow Working Together (WT) and Keeping Children Safe in Education (KCSIE). We think that the 'what works' elements of the guidelines will add the greatest additional value to schools.	Thank you for your comment. We have added reference to Working Together 2015 and Keeping Children Safe in Education to the introduction to the guideline. We have also referred to the relevant content of Working Together in the introductory text for relevant sections.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	8	6	Why children don't tell – they might not have language skills to do so. We need to ensure that we think about children with Special Educational Needs and Disabilities.	Thank you for your comment. We have made reference to communication difficulties and speaking English as a second language in to recommendation 1.3.1.
[National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	8	25	Need to say more about disabled children and why they are ore vulnerable to abuse – it is about more than simply number of carers.	Thank you for your comment. We have amended the recommendation to simply state that disabled children are more vulnerable to abuse and neglect (recommendation 1.2.7). We agree that there are multiple reasons for this. However, the committee thought that the main implication for practice was for practitioners to be aware of the increased vulnerability in this group.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	10	Box 1	We think there might be quite an overlap between emotional states and autism. How can we advise staff to to make differential assessments of possible hypotheses for what they are seeing?	Thank you for your comment. We have added explanatory text under 'Alerting features for abuse and neglect' to state that 'As highlighted in the recommendations below, alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to consider the possibility of abuse or neglect as a cause for behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	12	20	Why repeatedly? Some of those things would be of concern if seen/heard once. We think the 'repeatedly' is unhelpful here.	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment. The inclusion of 'repeatedly' is to distinguish this from occasional instances.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	11	22	Wording is confusing – it sounds like you are referring to young carers. Being a carer increases vulnerability but is not inevitably an abuse per se.	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment. We agree that being a young carer is not abuse per se. However, in some instances having responsibilities could lead to the child being at risk of significant harm, which is what this recommendation is intended to alert practitioners to.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	14	24	Add in 'Parents who can't or won't use child's communication method'	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment and is based on the evidence reviewed by that guideline committee.
National Association of Independent Schools and Non-Maintained Special	SHORT	15	24	Health appointments – would be great to make the point that children are not 'did not attend' when it comes to missed appointments – it's a case of 'was not brought'.	Thank you for your comment. This recommendation (now 1.3.41) has been amended to refer to parents bringing their

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Schools - NASS					children to appointments.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	16	7	What is parents seek private dental care for their children? Your wording suggests that this would not be OK!	Thank you for your comment. Reference to 'NHS' has been removed from recommendation 1.3.43.
[National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	22	1	Add 'within 24 hours'	Thank you for your comment. This recommendation has now been removed on the grounds that these practices are already set out in Working Together 2015.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	23	34	Attachment difficulties may also be due to disability and foster carers? Read for meaning	Thank you for your comment. It is unclear which part of the document this refers to (there is no line 34). We were also unable to find the wording you have cited.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	27	19	Why only girls? It's not clear why this would not also work for boys that have been abused.	Thank you for your comment. The evidence on which this recommendation is based was a study undertaken with girls only. The guideline committee did not think it was appropriate to extrapolate this recommendation to boys. However, recommendations 1.7.17 to 1.7.19 are three possible options for children who have been sexually abused. The options in 1.7.17 and 1.7.18 would be available to boys also. We have included explanatory text at the beginning of this section as to why some recommendations are targeted at a specific population only.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	28	9	Shouldn't be using 'early help' where there are abuse and neglect known cases – possibly at 'safeguarding concerns' stage. We think this gives an unhelpful message.	Thank you for your comment. Reference to early help has been removed from this recommendation (now 1.8.3).
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	29-43		Glossary – definitions don't match definitions in WT and KCSIE, which is likely to make guideline confusing for those working in education.	Thank you for your comment. We have now amended the definitions of abuse and neglect in the glossary to be consistent with the definitions in Working Together 2015.
National Association of Independent Schools and Non-Maintained Special Schools - NASS	SHORT	37	10	Take out 'taking the lead professional role' should be those working directly with children – everyone has a responsibility.	Thank you for your comment. This has been amended as you suggest.
The National Deaf Children's Society	Full	11	1.14	We would suggest that adding to this paragraph the following: *.."For disabled children the worker should also consider the suitability of the environment itself to ensure the child is able to communicate effectively given their specific needs*.	Thank you for your comment. Recommendation 1.1.4 now makes specific reference to sensory processing issues.
The National Deaf Children's Society	Full	11	1.16	We would suggest that this statement should include: *"..or suitably accessible equivalent format to meet the child's communication…"*	Thank you for your comment. Recommendation 1.1.6 has been amended as you suggest.
The National Deaf Children's Society	Full	25	1.3.10	We strongly agree with this. In our research the impact of deafness is often not understood by children's social care given that deaf children are often excluded by criteria to access children's social care disability teams where there is no specialist expertise. Such teams have eligibility criteria which equates a medical prescribed severity of deafness and multiple disabilities with severity of need.	Thank you for your comment. We hope that this recommend will encourage changes to practice in these areas.
The National Deaf Children's Society	Full	27	1.4.12	We would suggest that added to this the following " *useful.. including relevant charities or support groups related to the children or families needs".*	Thank you for your comment. This recommendation is intended to include local charities and support groups.
The National Deaf Children's Society	EI Assessment	Question 3.1		***"Disability:** The Committee considered evidence relating to disabled children particularly regarding whether disabled children are at increased risk of abuse or neglect, and specific considerations required as part of assessing and communicating with disabled children (see recommendations 1.1.2, 1.3.7 and 1.4.7)."* Having referred back to the full draft guidance we cannot see how 1.3.7 and 1.4.7 as stated above are related to disabled children.	Thank you for your comment. Apologies, the numbering in the EIA was incorrect. Recommendation 1.3.7 should have read 1.2.7 and 1.3.7 should have read 1.3.10 (now 1.4.6). This has been amended in the EIA document.
The National Deaf Children's	EI Assessment	Question 3.1			Thank you for your comment.

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Society				We would also agree with the NSPCC who stated in their 2014 report *We have the right to be safe. Protecting disabled children from abuse* (2014) "There is a lack of evidence-based research that defines the full extent and nature of abuse of disabled children, identifies the barriers to effective protection and measures outcomes of success for interventions."	Recommendation 1.2.7 highlights the increased vulnerability of disabled children.
Nene and Corby Clinical Commissioning Group	Full	General	general	The full report if it remains at 500 plus pages needs to be well indexed so that particular guidance can be sought easily	Thank you for your comment. There is a shorter version of the guideline (54 pages) which is the version NICE would expect pracititoners to refer to. The longer version provides details of all the evidence reviewed for those wishing to know more. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
Nene and Corby Clinical Commissioning Group	Short	General	general	The recommendations talks about Gillick competence should we not we using Fraser guidelines?	Thank you for your comment. It is NICE standard practice to refer to Gillick competency but not to the Fraser guidelines.
NHS East and North Hertfordshire	full	11	1.1.5	Consent should be sought from a child who is verbal. This is good practice for all professionals otherwise what message are we giving to children'.	Thank you for your comment. We have clarified in recommendation 1.1.5 when consent should be sought from a child, and when from a parent, linked to Gillick competence.
NHS East and North Hertfordshire	full	13	1.21	This section does not take into account that a child may not understand /know they are being abused but may feel something is wrong. Unless professionals take this into account wrong decision may be made	Thank you for your comment. The bullet point in recommendation 1.3.1 stating that children may not recognise their own experiences as abusive or neglectful is intended to convey this.
NHS East and North Hertfordshire	Full	13	1.2	Neglect assessment tool must be used to measure level of Neglect - examples are Graded Care Profile Known as CGP or other assessment tools. Otherwise it is subjective	Thank you for your comment. We reviewed evidence in relation to the Graded Care Profile, but the committee considered this to be insufficiently strong to support a recommendation. It is our understanding that it is not a statutory requirement to use particular tools to assess neglect.
NHS East and North Hertfordshire	Full	15	1.2.10	Not Brought In" here (it is mentioned in another part of the document but I feel it should be here also). In section I would like to see "Not Brought In" here (it is mentioned in another part of the document but I feel it should be here also). There is also no mention of parents demonstrating aggression towards professionals which I would say is important when looking at historical child death cases. There is also no mention of parents demonstrating aggression towards professionals which I would say is important when looking at historical child death cases. There is no mention of the "Rule of Optimism" which again is cited in child death cases (such as Baby P)	Thank you for your comment. As you note, parents not bringing children to medical appointments is mentioned in recommendation 1.3.41 as an alerting feature for abuse and neglect. Recommendation 1.2.10 (now 1.2.4) is based on empirical evidence showing an association between the factors mentioned and abuse or neglect. We did not find evidence relating to aggression towards professionals. The intention is that this, and the other risk factors and alerting features mentioned in the guideline, would help to guard against the 'rule of optimism' by highlighting aspects of behaviour that should be concerning.
NHS East and North Hertfordshire	full	15	1.2.12	There is very little information about the recognition of any sort of Attachment Disorder which may result in incorrect referrals to relevant service	Thank you for your comment. There is a separate NICE guideline on attachment.
NHS East and North Hertfordshire	Full	17	1.2.15	There is mention of self-harm being a behaviour associated with current/past abuse, mental health (including depression) is not cited.There is much evidence that Looked After Children suffer Mental Health than their Peers.	Thank you for your comment. We did not review evidence about the association between mental health problems and abuse or neglect, on the grounds that children and young people with diagnosable mental health problems would receive treatment and support on this basis.

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NHS East and North Hertfordshire	Full	20	1.2.31	Where emotional abuse is discussed, there is little dialogue in relation to children with caring responsibilities Where emotional abuse is discussed, there is little dialogue in relation to children with caring responsibilities	Thank you for your comment. Recommendation 1.3.18 refers to children and young people with responsibilities that interfere with their normaly daily activities.
NHS East and North Hertfordshire	Full	20	1.2.37	No discussion as to what quantifies as excessive physical abuse. This may lead professionals/others to make incorrect decisions in absence of advice/guidance from safeguarding professionals	Thank you for your comment. This recommendation has been removed following consultation feedback.
NHS East and North Hertfordshire	Full		1.5.4	With assurance in mind, there a number of recommendations for agencies in relation to recognition and response to Child abuse and Neglect but nowhere does it discuss how we can be assured that agencies are doing what they have been requested to do	Thank you for your comment. The processes that should be followed by different agencies, including escalation processes if the required response does not occur, are set in Working Together 2015. They have therefore not been replicated in this document.
NHS East and North Hertfordshire	Full	50	2.7	Refers to anecdotal evidence and research that is poorly referenced.	Thank you for your comment. It is not clear which part of the document your comment refers to (there is no 2.7 on page 50).
NHS East and North Hertfordshire	Full	52	3.0	NICE Manual referenced incorrectly.	Thank you for your comment. It is not clear which part of the document your comment refers to (there is no 3.0 on page 52).
NHS East and North Hertfordshire	Full	56	3.1	No reference to Graded Care Profile within section addressing recognition of abuse and neglect	Thank you for your comment. We reviewed evidence on the Graded Care Profile as part of the review question on assessment approaches (see Section 3.5). However, the committee did not think this was sufficiently strong to support a recommendation.
NHS East and North Hertfordshire	Full	68	3.1	Refers to a 'helpless outlook' without a clear definition or clarification as to how this was measured/assessed	Thank you for your comment. We have amended this sentence to make it clearer that this referred to whether children viewed others as a source of help.
NHS East and North Hertfordshire	Full	98		Reads well and the presentation of studies in the tables was easy to digest along with the explanation. My one comment is on under the title 'learning disability' the text goes straight in to talking about a 'mental or intellectual disability' and I wondered whether this needed a clear definition under the title 'learning disability' or if the title needed to be renamed to 'mental and intellectual disability'.	Thank you for your comment. We have used the term learning disability for the heading of this section as this is the term preferred by NICE, and in more common usage. The term 'mental or intellectual disability' was the one used by the study authors. However, we have put this in inverted commas as it is our understanding that this would no longer be the preferred term.
NHS East and North Hertfordshire	Full	173		Studies that require consideration are Havard centre on the developing child applying the science of Child development in Child welfare systems.Http://46y5eh11fhgw3ve3ytpwxt9r.wpengine.netda-cdn.com/wp-content/uploads/2016/10/HCDC Child Welfare Systems.pdf	Thank you for your comment, and for suggesting this paper. Screening on title and abstract suggests that this is not an empirical research study and so would not meet our inclusion criteria.
NHS East and North Hertfordshire	Full	175		No mention of purpose built child protection and sexual abuse examination suites/settings	Thank you for your comment. These would be covered under the umbrella term 'all settings' – the bullet point list gives examples but is not exhaustive.
NHS East and North Hertfordshire	Full	179		Family assessment strengths and needs tool see The Intergenerational Mobility Project http:// developing child .havard.edu/innovation-application/innovation-inaction/intergen-17mobility-project/	Thank you for your comment. Unfortunately, we were not able to access information about the Intergenerational Mobility Project via the weblink you provided. However by carrying out searches on the project's name we were able to locate some of the project's webpages. We did not find any research on the project which could contribute to this guideline.
NHS East and North Hertfordshire	Full	189		Effective Communication –A workbook for Social Care workers Part of the knowledge and skills for social workers series London Jessica Kingsley Publishers. Cleaver,H. and Nicholson ,D (2007)Parental Learning Disability and Childrens Needs Family Experiences and Effective Practice London Jessica Kingsley Publishers.	Thank you for your comments. The review protocols for the Guideline specified that we would not use books as sources of data, and so we would not have been able to include the first two references you have

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				Foster et al 2007 Communication skills in Child protection: how do social workers talk to parents? Child and family Social Work. References provide further information not considered.	suggested.Title and abstract screening of Forrester et al. (2007) found that it did not meet our inclusion criteria on study design.
NHS East and North Hertfordshire		190		Confusion around definition of Early Help. Glossary :support provided early as soon as a problem emerges. Early Help can prevent a problem from worsening or further problems from arising. Some papers describe nurse home visiting based on pre existing criteria such as young age at pregnancy poverty not on detected or emerging problems	Thank you for your comment. There was not always a clear distinction in the literature between families with latent risk factors for abuse and neglect, and those showing early signs of abuse and neglect. A number of the papers we reviewed discussed interventions aiming to prevent used screening tools of multiple risk criteria as a way of assessing risk of abuse and neglect. As a pragmatic approach to this, in discussion with the guideline committee chair, we agreed a list of risk factors that we would accept as a proxy for 'early signs' of abuse and neglect. We also only included studies which measured their impact on incidence or risk of abuse and neglect.
NHS East and North Hertfordshire		402		Regarding CSE and forced marriage, it highlighted the poor recognition of the issue by professionals and lack of early help . It also highlighted for FGM, thee can be a lack of professional confidence in asking questions of girls and young women who may be at risk. However I would like to point out the knowledge of FGM /CSE issues have been taught for primary care physicians, Practice nurses and other allied healthcare team through our teaching and updates. This results in more reporting of this problems and helps to prevent further abuse to the vulnerable group.	Thank you for your comment. We are aware that this is a rapidly evolving area of practice, and may have changed since the expert witness gave their testimony.
NHS East and North Hertfordshire	3.9	409		Responding to abuse and neglect- aspects of professional practice that support and Hinder: 1. Professionals should try establish meaningful relationship with chid and family so that they can come forward to report these issues to the authorities. there SHOULD BE A CONTINUITY OF CARE - the same professional should try to handle these problems rather than different persons for the same issues. Also communication with professional should be available to the children easily rather than going through complex process. 2. Children and families should be educated how to recognise CSE/ CHILD TRAFFICKING issues at the early stage. 3. Sharing of information among the different agencies is of paramount importance. 4. Cultural belief and sensitivities are important however that should not be used as a cover for these kind of abuse. 5, Enough resources should be allocated to deal with this kind of abuse as it is hidden most of the occasions.	Thank you for your comments. It is not clear which section of the document you are referring to, so we have referred to page 409 of the long guideline. Dealing with each in turn: 1. Recommendation 1.8.1 suggests that senior managers should plan services in such a way as promotes continuity of care. 2. We have not made recommendations relating to families' own recognition of CSE and child trafficking, although parents could make use of the information on alerting features in this guideline. There will also be a separate version of the guideline for children and young people. 3. We have not made specific recommendations about information sharing as there is existing guidance in Information sharing advice for safeguarding practitioners. 4 and 5. Recommendation 1.8.3 recommends that local threshold documents should set out responses to a range of form of 'hidden' abuse, some of which have an association with particular cultures, in recognition of the fact that addressing these forms of abuse is challenging.
NHS East and North Hertfordshire	full			**General Comments** There is no mention of educational ability of parents – either those parents with LD and how we assess their level of understanding of what is actually been asked of them and as well as this, parents who are highly articulate and manage to divert the attention of professionals. Exploration of the impact of ethnic, cultural and religious factors appears to be absent. there appears to be discussion around asking "open questions" but not much clarification about what this really means .	Thank you for your comments. Thank you for your comment. Recommendation 1.1.10 now makes reference to parental learning disability, and 1.1.11 makes reference to meeting the communication needs of parents. Recommendation 1.1.10 also refers to the importance of being sensitive to cultural and religious needs. In relation to asking open questions, we

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				There is no mention of the "Rule of Optimism" which again is cited in child death cases (such as Baby P). There is no mention of educational ability of parents – either those parents with LD and how we assess their level of understanding of what is actually been asked of them and as well as this, parents who are highly articulate and manage to divert the attention of professionals. . There is no link in relation to Training of staff to the Intercollegiate document to indicate level of training required. There is no mention of the Graded Care Profile, outcome star or any other appraisal/measurement tool for assessment of Neglect. There is a lot of discussion with respect to assessment of CA&N and dialogue about conceptual models without much thought in relation to what these might look like. It is pleasing that there is discussion about appropriate explanation of process to children and quite a section on capturing the voice of the child but there does not appear to be many thoughts on how we can be assured that the child actually understands. I would ask how we can be assured that the voice of the child and the child's ability to communicate is captured. The Draft Guideline does not deal at all with Fabricated and Factitious Illness (FII), a massive omission. This would confirm many practitioners' impression the official bodies think FII does not exist or would like it to go away. This document is very repetitive as to method No reference to the Family Safeguarding work taking place in Hertfordshire and being evaluated by Bedfordshire University.	have directed practitioners to the Ministry of Justice's Achieving best evidence in criminal proceedings, which sets out how to work with children and young people without prejudicing formal investigations. The intention is that this, and the other risk factors and alerting features mentioned in the guideline, would help to guard against the 'rule of optimism' by highlighting aspects of behaviour that should be concerning. The intercollegiate document is now referenced in recommendation 1.3.10 regarding training for practitioners in primary care. We searched for evidence on assessment tools, aiming to find evidence on practical tools currently in use (not just conceptual models) but found few studies which met our quality criteria. We did review evidence on the Graded Care Profile as part of review question 8 about approaches to assessment, but the guideline committee judged this to be insufficiently strong on which to base a recommendation. With regard to checking that children understand, recommendation 1.1.6 makes reference to this, and providing children with information in a format the can understand. With regard to fabricated and induced illness, this is covered in the NICE guideline on child maltreatment. We have now specifically signposted the relevant recommendations in recommendation 1.3.44. We acknowledge that the document contains a lot of detail regarding methods, some of which is the same in different sections. This is so that people can refer to only the section they are interested in, and find all the detail they want. With regard to the Family Safeguarding work in Hertfordshire, this did not appear in our evidence search. Our searches suggest that this study has not yet been published.
NHS England (London region) Safeguarding Team	Short	5	general	Within page 5, physical examination – consideration of the MCA has not been mentioned for over 16 yrs.	Thank you for your comment. The Mental Capacity Act is now mentioned in recommendation 1.1.5.
NHS England (London region) Safeguarding Team	Short	20	1.4.9	There is no mention of early help or support for parents with a learning disability, it mentions low level of education but this is not the same thing and these parents may need an increased level of multi-agency support at an early stage	Thank you for your comment. None of the evidence we reviewed stated that the study population included parents with learning disabilities (although it is likely that some of the participants would have had a learning disability). We have therefore not made specific reference to this population in the recommendations.

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					We have added introductory text at the beginning of this section, stating that where interventions are recommended for particular groups, this reflects the evidence base for this intervention.
NHS England (London region) Safeguarding Team	Short	19-20	General	Can there be some emphasis on ensuring information is accessible for parents who have a learning disability – early support info, information regarding the safeguarding process. Links with teams who can offer more specialised support to parents that have a learning disability and ensuring parents who have a learning disability have access to an advocate.	Thank you for your comment. Thank you for your comment. Recommendation 1.1.10 now makes reference to parental learning disability, and 1.1.11 makes reference to meeting the communication needs of parents.
NHS England (London region) Safeguarding Team	Short	10	general	As children with a learning disability have been found to be at significantly increased risk compared to non-disabled children of 'any' type of violence/maltreatment would it be useful to have a link to or reference specific advice regarding how this cohort might communicate or signs etc. For example not to diagnostically overshadow and relate their behaviour to the learning disability or mental health problem	Thank you for your comment. We have added text at the beginning of the section on alerting features reminding practitioners to continue to consider abuse and neglect as a possibility, even if it is apparently explained by other factors such as learning disability. Recommendation 1.1.2 also refers to communication needs.
NHS England (London region) Safeguarding Team	Short	42	General	Could the research recommendation: Effective interventions for addressing abuse and neglect in the UK also include health (there may be a reason it hasn't)	Thank you for your comment. This research recommendation specifically focused on the social care and voluntary sectors as there was a particular paucity of high quality research evidence in these sectors. The rationale for research recommendation 2.9 in the full guideline has been amended to make this clearer.
NHS England (London region) Safeguarding Team	Short	5	1.1.5	For a medical examination a parent/guardian/chaperone should be present	Thank you for your comment. This recommendation aimed to focus on getting consent before touching a young person (rather than issues of consent in general) as children and young people who have been abused may have particular difficulties with being touched.
NHS England (London region) Safeguarding Team	Short	22	26	Children who have experienced domestic violence	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment. It is intended to focus on alerting features related to children's clothing or footwear.
NHS England National Safeguarding	Full	General	General	The document, at 500+ pages is too long. The research papers outlined could be included as hyperlinks, which would make the document more user friendly	Thank you for your comment. There is a shorter version of the guideline (54 pages) which is the version NICE would expect pracititoners to refer to. The longer version provides details of all the evidence reviewed for those wishing to know more.We are unable to provide hyperlinks for research papers, but full references are provided so that people can follow up the original research if they wish. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
NHS England National Safeguarding	Full	General	General	Looked After Children are only mentioned twice in the whole document, one mention of unaccompanied asylum seeking children and nothing about missing children. There is no reference to the statutory duties to meet looked after children's health needs as a particularly vulnerable groups. Only one mention of the voice of the child.	Thank you for your comment. There is an existing NICE guideline on services to support the health and wellbeing of looked after children. Recommendations 1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.1.6, 1.1.7 and 1.4.1 relate to communicating directly with children and hearing their voice.

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NHS England National Safeguarding	Full	General	General	The references are incomplete throughout the document, and the hyperlinks are in the incorrect font (lower case)	Thank you for your comment. References and hyperlinks are formatted according to the NICE style guide. References for included studies can be found under the 'Included studies for this section' sub-heading in sections 3.1 to 3.10 and in Section 5 References.
NHS England National Safeguarding	Full	General	General	I found the layout very confusing, repetitive, incomplete (CSE section) and the I lost interest after page 300, although I did read the whole paper.	Thank you for your comment. We acknowledge that the document contains a lot of detail regarding methods, some of which is the same in different sections. This is so that people can refer to only the section they are interested in, and find all the detail they want. With regard to CSE, we found little evidence in relation to this topic, which is why we invited an expert witness. Their testimony is summarised in sections 3.6 and 3.8, and can be found in full in Appendix D.
NHS England National Safeguarding	Short	General	General	Very confusing layout, poor typeset and missing points. This summary has issues with its presentation, as the reader should be led in a thematic way to develop their learning. Lots of points 'stating the obvious'	Thank you for your comment. The short guideline has been organised broadly according to a care pathway of recognition, assessment, early help, response and therapeutic support. This guideline has aimed to add further detail to existing guidance by making evidence-based recommendations which have been shown by empirical evidence of being as of particular importance, or not always working well in practice.
NHS England National Safeguarding	Short	General	general	No recommendations for LAC, unaccompanied asylum seekers or missing children (Education would note this omission too, as you do not discuss missing from education.	Thank you for your comment. Recommendations 1.7.8, 1.7.9, 1.7.12, 1.7.13, 1.7.15, 1.7.16 are for children who are in alternative care placements or who are adopted. This would included unaccompanied asylum seeking children, as there are also categorised as looked after children. There is also a separate NICE guideline on the health and wellbeing of looked after children. Recommendation 1.3.17 refers to chidlren who have run away from home or care.
NHS England (Children's and Young People's Mental Health Team)	Short	General	general	We've had feedback that this is a rather long document which may be difficult for professionals to digest at speed.	Thank you for your comment. Following stakeholder feedback, we have worked to make the short guideline more user-friendly, including setting out which sections are relevant for different audiences. A concise 'quick guide' version of the guideline for practitioners will also be developed. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
NHS England (Children's and Young People's Mental Health Team)	Short	General	general	Is this an update or to be read alongside the 2009 guidance or does it replace it?	Thank you for your comment. This guideline is designed to be read alongside the 2009 guidance in the NICE guideline on child maltreatment. We have added an explanation of this in to the introductory text for the guideline.
NHS England (Children's and Young People's Mental Health Team)	Short	General	general	Who is this guide for and who is intended to carry out the recommended actions? The instructions are all addressed to 'you' but appear to be for different professionals for example: 1.2.46, Supporting practitioners to recognise abuse and neglect - Ensure all practitioners working in primary care can recognise and respond to child abuse and neglect.	Thank you for your comment. Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6,

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				1.4.13 Ensure that all practitioners working at the early help stage: - understand the parental risk factors for child abuse and neglect (see 15 recommendations 1.2.9 to 1.2.10) - are aware of the possibility of escalation of risk, particularly if family 17 circumstances change. NHS England (Children's and Young People's Mental Health Team)1.5.1 'You should expect to hear back from children's social care whether or not 1 action has been taken, and the timescale of this action.' It would be helpful to address these directions to specific professionals – e.g. social workers need to XXXX; commissioners of mental health services need to XXXX, and so on – rather than 'you'.	1.7 and 1.8, to make clearer who the audience is for each section, and who should take action. With regard to your specific points: recommendation 1.2.46 (now 1.3.10) has now been reworded as being aimed at commissioners; recommendation 1.4.13 (now 1.5.6) has been reworded as being aimed at commissioners and managers; recommendation 1.5.1 has been removed.
NHS England (Children's and Young People's Mental Health Team)	Short	9	4-11	There are some concerns about the mental health trigger for considering abuse/neglect: *Consider abuse and neglect if a parent, carer, sibling or other adult in a 4 child's household has 1 or more of the following risk factors: 5* *They have substance misuse difficulties. 6* *There is a history of domestic abuse. 7* *They are emotionally volatile or have problems managing their anger. 8* ***They are experiencing mental health problems.*** Does this stigmatise parents with MH problems? – Perhaps replace with "parents suffering a condition (physical or mental) that might impact on their parenting"? (Neglect would be perfectly possible for example if parent is physically inhibited in carrying out the day-to-day responsibilities of parenting.)	Thank you for your comment. This recommendation (now 1.2.3) has been reworded to make it clear that mental health problems are a vulnerability factor. We have added explanatory text in the introduction to this section to highlight that the presence of these factors increases vulnerability to abuse and neglect, but is not deterministic of abuse or neglect. Professional judgement should be used to assess the significance of these factors.
NHS England (Children's and Young People's Mental Health Team)	Short	general	general	The guidance moves from when to consider or suspect abuse/neglect straight to assessment. It might be helpful to also look at the step in between – i.e. how you move from suspicion to assessment.	Thank you for your comment. We have added more detail to this section regarding what steps practitioners should take if the suspect abuse or neglect in terms of making a referral to children's social care (or police as necessary).
NHS England (Children's and Young People's Mental Health Team)	Short	General	general	We couldn't see a reference in the main text to Routine Sensitive Enquiry, which is government policy and also an important trigger for suspecting abuse/neglect. There is 'consider past abuse' in the first section – but not a sense of how a service (like a children and young people's mental health service) might routinely check in on this in an appropriate way.	Thank you for your comment. The response in this guideline is based on the steps outlined in What to do if you're worried a child is being abused.
NHS England (Children's and Young People's Mental Health Team)	Short	22	15-25	*Ensure that all children and young people who have been abused or 15 neglected are given a minimum of: 16* *a safe place to live 17* *an opportunity to be actively listened to and believed 18* *support to explore aspects of their experience and express their 19 feelings 20* *early emotional support, including building emotional resilience and 21 strategies for coping with symptoms such as nightmares, flashbacks 22 and self-harm 23* *support to reduce the risk of further abuse if appropriate, for example if 24 a young person is at risk of sexual exploitation.* Can we add 'assess MH needs and follow up to arrange support where appropriate'?	Thank you for your comment. We have added reference to this in to recommendation 1.6.2.
NHS England (Children's and Young People's Mental Health Team)	Short	23	24	For the children under 5 section, it may be helpful to reference the Children And Young People's Improving Access to Psychological Therapies (CYP IAPT) curriculum for 0-5s, which some professionals in children and young people's mental health services are being trained in. It includes sections on abuse and neglect: **0-5s curriculum on evidence-based developmental**, infant and child mental health interventions Under fundamental core skills: Assessing risk to the child of physical, sexual, emotional abuse and neglect; risks posed by the child to self and others; recognising caregiver behaviours associated with abuse and neglect Other CYP IAPT curricula that may be relevant to reference in this guide include: Evidence Based Psychological Therapies for CYP with mental health problems and **autism spectrum disorder and/or a learning disability**. An understanding of the impact of trauma/abuse/loss on an individual with Autism or Learning Disabilities and how these might have an impact on presentation How to develop a risk plan (including self-harm, harm to others', self-neglect, break down of family/carer or residential support, exploitation or abuse by others) and or signpost when necessary to urgent services. **Whole team training for community eating disorder teams** – the team are required to hold knowledge on …. This must include the relevance of co-occurring conditions (mental and physical), and groups that are especially at	The recommendations in this section are aimed at child and adolescent mental health practitioners. This can include those working with Children and Young people's Improving Access to Psychological Therapies programmes.

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				risk or face particular issues, (e.g. males, individuals with learning disabilities) and those who may have experienced physical, sexual or emotional abuse.	
NHS England	Short	19		Slight worry that it is not clear at whom the recommendations around for example home visiting is aimed at. Comment extends further – when usual general term such as consider… -needs clarification	Thank you for your comment. Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action.
National Network of Parent Carer Forums (NNPCF)	Full and short	General	general	• We welcome the further clarification to strengthen the safeguarding arrangements for children and young people. However we are concerned that there is lack of clarification in the current draft Guidelines of how the legal processes in Early Help and Section 17 and 20 of the Childrens Act relate to children with disabilities and their need for social care support to help them live positive lives. • Without support from social care such as from short breaks these Children and Young People (CYP) can suffer "harm" from not being able to live a meaningful life like other children as they need more specialist support (so it is NOT harm in a "safeguarding" but in terms of failing to achieve positive outcomes by being unable to live a life like other CYP). • The Aiming High for Disabled Children's framework and the subsequent short breaks legislation recognised that many disabled children and young people and their families need additional support and services to lead good and fulfilling lives reflecting their needs and disabilities. • We are very concerned that if necessary caveats are not put into these Guidelines about SEND and factors that can and do arise from SEND, that are also identified as "soft" signs of abuse, they will be ignored/dismissed or forgotten by those referring to the Guidelines. This could lead to wrong claims being made by for example schools and to CYP and families with SEND not getting the support to which they are entitled under the Education. Health and Social Care systems. • The role of social care therefore needs to be clarified in these Guidelines in relation to CYP with SEND. • We also need to see greater recognition and understanding of the strain that caring 24:7 has on families and that there needs to be greater recognition of this impact, especially as Short Breaks budgets in Local Areas are squeezed. • Whilst it's important for professionals to be aware of the "soft" signs, these could be easily confused with the child's disability. We would therefore like **separate sections/or a separate section dealing with CYP with SEND providing much more info/detail and guidance and not putting all CYP together.** Guidance should be that all professionals working with the C/YP should be familiar with their disability and how this presents itself before coming to a decision. They should all have training in dealing with challenging behaviour. If professionals know the child well, they should only make a judgement if the child's behaviour changes - ie not their normal behaviour. • Whilst this deals with safeguarding CYP, should there be mention if parents are being abused by their CYP? What's the guidance to professionals then? This was discussed at a recent event in London #VCB2017 • A recent Social Care and Innovation Fund CDC led project looking at social care and children and young people with disabilities recognises that there are particular issues in the system that can affect how social care interacts with Children and Young People with Special Educational Needs and Disabilities (SEND) and their families. The questions the project sought to answer were: • Why do we not value work with this group of families as we do with others? • How do we make effective use of resources so that staff work to their skills and strengths and families get the right intervention at the right level and at the right time? • How do we work in true partnership with families while always remembering that the welfare of the child is paramount? • How do we ensure that in working with families we build resilience and not dependence? How do we ensure that families have the most positive of lives while always acknowledging the additional resources raising a child with a disability entails?	Thank you for your comments. Thank you for your comment. As the focus of the guideline is child abuse and neglect, we have therefore focused on how the legislation applies to this group.
National Network of Parent Carer Forums (NNPCF)	Full and Short	4 and 5	"Introduction"	• The context of referrals under Early Help or Section 17 of the Childrens Act implying all referrals to social care could be seen as potential cases of abuse and neglect implies a misunderstanding of how the social care system works for CYP with SEND and their families under the relevant legislation. • For example certain specialist services (e.g. hospice care or overnight short breaks) and certain levels of support under the Children in Need legislation require referrals to, assessments by and decisions by social care teams. Local areas are expected to have systems in place that ensures that families know how to access the right levels of social support (e.g. through universal, targeted and specialist services) based on needs of the CYP and family. • While we agree with the sentiments in this paragraph, the implication of the use of the words "although not all of these [referrals] resulted in substantiated cases of abuse or neglect" could be seen to imply (wrongly) that all families and children and young people with disabilities who seek help to improve their social (care) outcomes are unsubstantiated cases of abuse and neglect. "Cruelty to children is a criminal offence, and abuse and neglect can have serious adverse health and social consequences for children and young people, which can persist in to adulthood. In the 1-year period from 1 April 2015 to 31 March 2016 there were 621,470 referrals to children's social care, although not all of these resulted in substantiated cases of abuse or neglect (Characteristics of children in need in England 2015	Thank you for your comment. As the focus of the guideline is child abuse and neglect, we have therefore focused on how the legislation applies to this group.

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				to 2016 Department for Education). During this period 50,310 children and young people were the subject of a 'child protection plan', with the most common reasons cited as neglect (46%) and emotional abuse (35%)." • Additionally Section 20 of the Childrens Act applies in cases for CYP with SEND attend 38 or 52 week residential schools when these decisions are not made on safeguarding grounds but to ensure the education of the children. These draft guidelines do not make that distinction clear referring or implying this happens only in relation to safeguarding decisions.	
National Network of Parent Carer Forums (NNPCF)	Full and Short	6 - 9 (Full)	"Context" paragraphs	Legislation should also include: • Care Act 2014 • Children and Families Act 2014 including SEND provisions and those relating to Education Health and Care Plans • Section 17 of the Children Act 1989 - safeguard and promote the welfare of 'children in need' in their area, including disabled children, by providing appropriate services to them. These services might include short breaks for parent carers, equipment or adaptations to the home. • Section 2 of the Chronically Sick and Disabled Persons Act 1970 - duty to provide services to individual disabled children arises where it is 'necessary' to provide services to the child – a question that can only be answered once there has been a proper section 17 assessment • Short Breaks Duty "Breaks for Carers of Disabled Children Regulations 2011" • Key principles = integration (between service areas), early intervention, improved outcomes	Thank you for your comment. As the focus of the guideline is child abuse and neglect, we have focused specifically on legislation relating to this group. The Children and Families Act 2014 is referenced on page 50.
National Network of Parent Carer Forums (NNPCF)	Full and short	6 - 9 (Full)	"Context" paragraphs	• The Government provided £800 million between the spending review period of 2011 and 2014 on Short Breaks through the unringfenced Early Intervention Grant. • The Government also made a commitment to Short Breaks through the implementation of a new Short Break Duty which came into effect from April 2011. • This created a legal duty on local authorities to provide a range of Short Break services including: • Overnight care in the homes of disabled children or elsewhere • Day time care in the homes of disabled children or elsewhere • Educational or leisure activities for disabled children outside their homes • Services available to assist carers in the evenings, at weekends and during the schools holidays.	Thank you for your comment. We have not referenced this as it does not relate specifically to abuse and neglect.
National Network of Parent Carer Forums (NNPCF)	Full and Short	6 - 9 (Full)	"Context" paragraphs	• Focus on outcomes for Children and Young People (CYP) with SEND in Children and Families Act 2014. Recognising that these outcomes for CYP with SEND have historically been poor these outcomes are: • Employment - Health - Independent living - Friends, relationships and community participation • All CYP with SEND have social needs like any other CYP • Social Care does not mean all CYP with SEND need a social worker • EHCs should not say "not known to social services" or "no social needs" • Equalities Act and reasonable adjustments (schools etc) • Inclusion – understanding universal, targeted and specialist services • Paragraph 9.35 of the SEND Code of Practice - where particular services are assessed as being needed, such as those resulting from statutory social care assessments under the Children Act 1989 or adult social care legislation, their provision should be given to the child and family as soon as a need is identified and not wait until the completion of an EHC needs assessment. • The SEND Code of Practice states that the Local Offer has two key purposes: • To provide clear, comprehensive, accessible and up-to-date information about the available provision and how to access it, and • To make provision more responsive to local needs and aspirations by directly involving disabled children and those with SEN and their parents, and disabled young people and those with SEN, and service providers in its development and review. It should not simply be a directory of services and the process of developing the Local Offer is intended to help local authorities and their health partners improve provision.	Thank you for your comment. We have not made reference to this aspect of the Children and Families Act 2014 as it does not relate specifically to child abuse and neglect.
National Network of Parent Carer Forums (NNPCF)	Full and Short	6 - 9 (Full)	"Context" paragraphs	• Local authorities and clinical commissioning groups (CCGs) must make joint commissioning arrangements for education, health and care provision for children and young people with SEN or disabilities (Section 26 of the CFA Act). • The term 'partners' refers to the local authority and its partner commissioning bodies across education, health	Thank you for your comment. We have not referred to this because it is not specific to abuse and neglect.

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				and social care provision for children and young people with SEN or disabilities, including clinicians' commissioning arrangements, and NHS England for specialist health provision. • Joint commissioning should be informed by a clear assessment of local needs. Health and Wellbeing Boards are required to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, to support prevention, identification, assessment and early intervention and a joined-up approach. • Under section 75 of the National Health Service Act 2006, local authorities and CCGs can pool resources and delegate certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised. • Need to understand populations to allow for personalisation	
National Network of Parent Carer Forums (NNPCF)	Full and Short	6 - 9 (Full)	"Context" paragraphs	• Transforming Care and IPC as context • Improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home. • Led jointly by NHS England, the Association of Adult Social Services (ADASS), the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH), the Transforming Care programme focuses on the five key areas of: • empowering individuals • Right care, right place • workforce • regulation • Data • IPC is a new approach to joining up health, social care and other services at the level of the individual. It enables people, carers and families to blend and control the resources available to them across the system in order to 'commission' their own care through personalised care planning and personal budgets.	Thank you for your comment. We have not referred to this because it is not specific to abuse and neglect.
National Network of Parent Carer Forums (NNPCF)	Full and Short	6 - 9 (Full)	"Context"	• National Parent/Carer Strategy Review being led by DH • Section 97 of the CFA 2014 amends the Children Act 1989 (by adding s17ZD to s17ZF) to require local authorities to assess parent carers on the appearance of need or where an assessment is requested by the parent. This is called a "parent carers needs assessment" • Care Act • Care Act/CFA not working as they should for parent/carers • Right to assessments and support in their own right • Needs to be better alignment to EHC and SEND processes • Disability Matters – Caring for Parent/Carers Matters – www.disabilitymatters.org.uk	Thank you for your comment. We have not referred to this because it is not specific to abuse and neglect.
National Network of Parent Carer Forums (NNPCF)	Full and short	Pp 15-17 (Full) Pp 9-11 (short)	"Indicators of abuse and neglect"	• Some of the markers of "behavioural and emotional states" and "emotional responses" are also markers of some developmental disabilities such as autism, learning disability, challenging behaviour. • CYP with SEND are also more at risk of being bullied and as the AntiBullying Alliance (ABA) says "Disabled children and children with special educational needs (SEN) are significantly more likely to experience bullying. You can read more research about this here. ABA have been leaders in the field of reducing what we refer to as disablist bullying (by disablist bullying we mean bullying of disabled children and children with SEN) via our All Together programme which has seen great outcomes at reducing bullying. You can read more about this here. Through this programme we have created many resources to support school staff, the children's workforce, disabled young people/young people with SEN and parents and carers. All of our resources have been influenced by consultation with young disabled people. Many of the resources have been developed with our programme partners Achievement for All, Contact a Family and the Council for Disabled Children amongst many other charities and	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendation 1.2.7 highlights that disabled children and young people are at increased risk of abuse and neglect.

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				individuals." • The Lenehan report "These are our children" in January 2017 highlights the needs of a group of these CYP with some of the most complex needs. This report states *inter alia* "9. At least 2.5% of the general UK population has a learning disability that means they will need specialist services at some point in their childhood (Emerson & Hatton, 2008). Nearly 40% of this group will experience significant psychiatric disorder, compared with less than 10% of those without a learning disability (Emerson & Hatton, 2007). This seems to be a consequence of innate factors that confer vulnerability, compounded by a range of external factors Factors contributing to mental health problems in this population • Communication difficulties • Limited coping strategies and social skills • Coexistent disorders * Neurodevelopmental disorder – notably ASD and ADHD * Psychiatric disorder – emotional disorder and psychosis * Physical health problems – epilepsy, immunological difficulties, sleep disorders • Child abuse (exposure to violence including bullying, abuse and neglect) • Out-of-home care (e.g. fostering, institutional placement) • Socioeconomic deprivation"	
National Network of Parent Carer Forums (NNPCF)	Full and short	All	General	• Locally challenges to understand the needs of families and CYP with SEND include: • Use of and understanding of eligibility criteria for short break and other disability social care services and support • Short breaks services statement – what does it say and is it resourced? • Role of different social care teams – early intervention (CAF), child protection – where do children with disabilities fit in? • Assessments (process not always clear) • Personalisation, higher levels of need and fairness • Continuing Care overlap and difficulties with health engagement and buy in • Universal, targeted and specialist social care support and what is in the Local Offer • 0-25 coverage (as required by Children and Families Act) • EHCs and social care within that	Thank you for your comment. The focus of this guideline is on abuse and neglect. We have therefore not covered other aspects of local provision including provision for disabled children and their families.
National Network of Parent Carer Forums (NNPCF)	Full and short	All	General	• The guidance on soft abuse also needs to be aware of the new **local area** inspections by Ofsted/CQC looking across education, health and care for all CYP with SEND 0-25. Successful implementation of the Children and Families Act 2014 requires joint working across all partner agencies as well as working with children, young people and their families to identify needs early, meet needs and improve outcomes. • The inspections will also consider coproduction with parent carers and young people individually and at Forum/strategic level. • Ofsted/CQC are focusing on the needs of all children and young people with SEND, those who have an	Thank you for your comment. It is encouraging that there is similarity between this guideline and the new local area inspections.

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				Education, Health and Care plan and those who access support through SEN Support and the Local Offer. • Local areas must know whether their provision is **improving outcomes** for ALL children and young people with SEND or not. They must agree aspirational yet realistic targets for young people and **monitor their progress** towards achieving them. • The fact social care is as much a part of this as are education and health is a measure of the importance of social care as an enabler to improve outcomes for some CYP with SEND and their families not for reasons of safeguarding but because they cannot easily access universal services that CYP without SEND can take for granted. • Inspection Reports have also highlighted the need to identify needs early and the delays that can happen when the necessary services are not commissioned and in place to do this (for example diagnostic services, CAHMS or therapies). In these cases family, the young people themselves and those who work with them may not understand some or all of the needs arising from SEND.	
National Network of Parent Carer Forums (NNPCF)	Full and Short	5, lines 1 and 2 (short)	Lines 1 and 2 communication needs	• communication needs, for example by using communication aids or providing an interpreter (**ensure the interpreter is not a family member**). • This part of the Guidelines could be seen as assuming neglect/abuse if child shows 'soft' signs which as we have said above may arise directly from a disability. This, with other parts of guidelines, could be seen as suggesting by implication that all family of disabled children and young people cannot be trusted. This needs to be tempered more with clearer references needs arising from to disabilities and what developmental needs means. It also needs to more clearly distinguish between issues arising from environmental factors and those arising from disability and not place the two together. We do not want all parent carers to be assumed to be under scrutiny where the CYP disability presents with what these draft Guidelines are calling "soft" signs.	Thank you for your comment. We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'Alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to be curious about behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
National Network of Parent Carer Forums (NNPCF)	Short and Long	Page 8 short	10 and 11	• 10 1.2.3 "Recognise that children and young people may communicate their abuse 11 or neglect indirectly through their behaviour and appearance (see NICE's 12 guideline on child maltreatment and recommendations 1.2.12 to 1.2.45 in 13 this guideline)." • This endorses the view of a person using these guidelines spots 'soft' signs as listed and assuming child is being abused/neglected. At very least there should be a caveat that these signs could arise out of a diagnosed (or underdiagnosed) SEND	Thank you for your comment. We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'Alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to be curious about behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
National Network of Parent Carer Forums (NNPCF)	Short and Long	Page 8 short	Line 25 et seq	• "1.2.7 For disabled children, be aware that their disability may increase the risk of abuse or neglect by their parents, carers or others, and make it harder to recognise. Also remember that disabled children may have many carers." • This suggests a presumption that all all parent carers may abuse or neglect their disabled child. Again, any of those 'soft' signs can appear in the most loving and nurturing of homes and viewing parents/carers in a deficit model is unhelpful to say the least. • The focus is also on parent carers and not on wider carers.	Thank you for your comment. This recommendation (now 1.2.7) no longer includes reference to carers.
National Network of Parent Carer Forums (NNPCF)	Short and Long	Page 9 short	To 1.2.9 and lines 16 and 17	• "Consider abuse and neglect if a parent, carer, sibling or other adult in a 5 child's household has 1 or more of the following risk factors: line 9 They are experiencing mental health problems." • Some parent carers do suffer from mental health problems alongside their SEND child displaying 'soft' signs but this does not mean they are being abused/neglected. • Lines 16 and 17 "The parent or carer has a mental health or substance misuse problem. There is chronic parental stress." The same comments apply to this.	Thank you for your comment. We have added the following text at the beginning of Section 1.2 to make clearer that these are vulnerability factors, not indicators of abuse or neglect: 'Vulnerability factors are factors that are known to increase the risk of child abuse and neglect. The presence of these factors does not mean that child abuse or neglect will occur, but practitioners should use their professional judgement to assess their significance in a particular child, young person or family. They should be considered in conjunction with the alerting features in section 1.3.'

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National Network of Parent Carer Forums (NNPCF)	Short and Long	Page 9 short	Lines 10 and 11	• "The risk factors above may be compounded if the parent, carer, sibling or 11 other adult in a child's household lacks support from family or friends." • Many families of SEND children are isolated and lacking in support. Again, this does not mean CYP is abused or neglected. • NNPCF wrote about this in for example its Transition Report It reflects that sometimes communities, friends and families do not understand disability and do not know how to support. Disability Matters aims to support the wider community reduce fears and be more inclusive. • Families whose CYP attend special schools and attend on school transport or who attend out of Borough placements are not likely to easily meet other families or have a "school gate experience"	Thank you for your comment. We have added the following text at the beginning of Section 1.2 to make clearer that these are vulnerability factors, not indicators of abuse or neglect: 'Vulnerability factors are factors that are known to increase the risk of child abuse and neglect. The presence of these factors does not mean that child abuse or neglect will occur, but practitioners should use their professional judgement to assess their significance in a particular child, young person or family. They should be considered in conjunction with the alerting features in section 1.3.'
National Network of Parent Carer Forums (NNPCF)	Short and Long	Page 9 -11 Short	Lines 25 to 28	• "General behavioural and emotional indicators of child abuse and neglect 1.2.12 Consider current abuse and neglect if a child or young person displays, or is reported to display, either of the following that differs from what would be expected for their age and developmental stage (see boxes 1 and 2):" And all of page 10 and most of page 11. • There should be very clear reference that all of these soft signs could indicated SEND rather than abuse/neglect. School refusal, self harm, repeated, extreme or sustained emotional responses, disassoiciation, wearing of inappropriate clothing, personal hygiene. etc etc could all be Autism/Learning Disability/ADHD/Challenging Behaviour and NOT abuse.	Thank you for your comment. We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'Alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to be curious about behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
Designated Safeguarding Children Team- Norfolk and Waveney	Short	general	general	All health providers in Norfolk and Waveney were asked to comment on this consultation so a county wide response could be given. The consensus is that this guidance is very detailed and clear for practitioners to use, however it is prescriptive and very long which may not be user friendly for some practitioners. Question 1: The recommendation in regard to providing attachment based therapies may be challenging due to the current unmet demand on mental health services, also there are current resource and retention issues around health visiting which will have a direct impact on being able to provide this intensive service to families. For this recommendation to be effective for vulnerable children and families more emphasis on collaborative working with other agencies needs to be encouraged. Within the document it also suggests that health have a responsibility for the assurance of other agencies, especially in respect to the police, when they are delivering a service to children and families which is something health practitioners do not have the authority to do. Question 2. The main cost implication is ensuring that there is an adequately qualified workforce who can deliver these recommendations. Question 3: It may be useful to include evidence based tools to help practitioners to identify child abuse, e.g. in Norfolk we use the Graded Care Profile when neglect is suspected and the Brook's Traffic lights to help identify sexual abuse, Signs of Safety which is a model we use across Norfolk when working with families to identify abuse and neglect.	Thank you for your comment. The guideline commitment considered carefully the resource impact of the recommendation on attachment-based therapies, which was adapted from the NICE guideline on attachment. No cost-effectiveness evidence was available for this intervention. The guideline committee discussed the availability of these types of interventions, and acknowledged that there may be variability in availability of staff to deliver these interventions across the country. However, the view of the committee was that the guideline could be used to encourage commissioning and greater consistency of provision. The committee also thought that it was important to make this recommendation based on the effectiveness evidence as a way of promoting best practice. We searched for evidence on assessment tools, aiming to find evidence on practical tools currently in use (not just conceptual models) but found few studies which met our quality criteria. We did review evidence on the Graded Care Profile as part of review question 8 about approaches to assessment, but the guideline committee judged this to be insufficiently strong on which to base a recommendation. We did not find evidence relating to Signs of Safety or the Brook's traffic lights which met our quality criteria.
NSPCC	Short	general	general	The NSPCC welcomes the opportunity to comment on the draft National Institute of Clinical Excellence (NICE) child abuse and neglect guideline.	Thank you for your comment. We have now added introductory text to the short guideline, explaining the purpose of the document and how it relates to other

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				The proposed guidelines are extensive, with a long and a short version and several supporting annexes. There is limited indication of how the guideline should be used by practitioners. There is also limited indication of how the guidelines relate to other key documents, including Working Together and other practice guidance documents. The guidelines would benefit from clarity about who the guidelines are for and how to use them if it wants to the desired impact of improving practice and protecting children from abuse and neglect. It is not practical to expect that individual professionals would be able to engage with a document of this complexity without additional support to help them understand it in the wider context. The draft guidelines cover a guide range of forms of abuse. However, at the NSPCC we are very concerned to see that at present they do not recognise the growing importance of online abuse. The NSPCC found in April 2016 that **the internet is used in eight cases of child sexual abuse every day, including rape, online grooming, and live-streaming of sexual abuse.**[1] The omission of online child abuse in these guidelines, therefore, is astounding and extremely worrying. Published research carried out on behalf of the NSPCC, looking at the impact of online abuse on young people, has highlighted specific characteristics of online abuse which impacts the severity of the experience. Online grooming makes victims particularly vulnerable as it often involves child sexual abuse images or videos, which may be available for others to view. The knowledge that their image can be repeatedly viewed and may never be removed contributes to the on-going trauma that victims face.[5] The exact numbers of children who have been subjected to online grooming is unknown. This is because in many cases, a child will not disclose the offences due to fear of the offender, shame at their perceived compliance with the offending, and embarrassment that their parents/carers will find out and punish them. It can also be because a child is not aware that they are being groomed. The NICE guidelines state that their purpose is to help all practitioners working with children and young people to recognise abuse and neglect, carry out an assessment, and provide early help and interventions to children, young people, parents and carers. In the case of online child abuse, every one of these processes require a radically different approach to those discussed in these guidelines for offline abuse. This must be recognised in the guidelines if we want to equip professionals with the right tools to address what is a growing form of abuse. We know that there is a lack of evidence surrounding therapeutic interventions for children who have experienced abuse online. That is why we think it is vital to clearly acknowledge this omission in research, and to state it among research priorities. We believe it is essential that NICE recognises online child abuse and provides clear guidelines for practitioners to respond to this. We would be happy to be contacted to assist with this.	guideline. A concise 'quick guide' version of the guideline for practitioners will also be developed. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance. Online grooming and abuse was within our definition of abuse and neglect. However, we did not find any studies meeting our quality criteria about effective practice or ways of working with abuse of this type. We have therefore made a research recommendation on this topic.
NSPCC	Appendix A	189	Review Question 14	We would recommend that Review Question 14 takes consideration of the NSPCC's process evaluation of the Glasgow Infant and Families Team (GIFT) programme in 2016. This service is currently being evaluated by an ongoing randomised control trial. The University of Glasgow has undertaken a qualitative evaluation of how the key features of GIFT impact on the wider system and barriers to implementation. GIFT is a multidisciplinary infant mental health team, consisting of psychologists, psychiatrists, social workers and support workers, delivering the New Orleans Intervention Model of assessment and intervention for children from the ages of 0 to 5. Over a 9 month period, the team provides: - detailed attachment-based assessments of the child and their parents; - An assessment of how well the child is coping; - an assessment of each parent's health and wellbeing, including mental health, any addiction issues, and the parent's exposure to trauma or violence; and - tailored therapeutic support to address problems and strengthen the parent-child relationship. Decisions about whether the child should be placed in care permanently are only made following the treatment programme, in order to reduce the number of children who spend long periods in temporary placements or are subject to failed rehabilitation plans. We also deliver this service in Croydon, as the London Infant and Families Team (LIFT). It is an example of evidenced	Thank you for your comment. Unfortunately we are unable to include this study. Our original search (all review questions) searched for evidence up to December 2014. The update search extended to April 2016 but was focused on the effectiveness questions only effectiveness questions only (5, 7, 9-13, 15-19). This is because it was felt that we had sufficient evidence in relation to the other questions, which related to aspects of professional practice, service user views and experiences and organisational factors. See the full guideline and Appendix A for more detail.

[1] BBC, 'Child sex abuse: more than 100 rapes with online link in last year', 2016, (available at http://www.bbc.co.uk/news/uk- 36578945).

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				positive systemic work to intervene early in the lives of children who are vulnerable to abuse and neglect, and provide the support that they and the families need.	
NSPCC	Short	1	4	The introduction to the guidelines outlines the forms of child abuse that are dealt with: physical, sexual, emotional abuse, neglect, and issues including child sexual exploitation, child trafficking and forced marriage. We are concerned about the omissions made here if it is to be understood as a comprehensive list. As previously discussed, online abuse needs must be included. Furthermore, it is important to clearly recognise in this list that the exposure of a child to domestic abuse is a form of child abuse. The exclusion of this from the list undermines the validity of a form of child abuse that is recognised by law. Exposure to domestic abuse, however, is extremely prevalent, with around 1 in 5 children found to be experiencing it in 2011.[2] It must be acknowledged in the introduction which does include less prevalent forms of abuse such as forced marriage. It should also make it clear that the list is not comprehensive to allow incorporating in the future other forms of abuse/neglect that may not be prevalent at the moment.	Thank you for your comment. The wording in the introductory section has been included to make clear that these are examples of forms of abuse and neglect. We found no empirical evidence that met our criteria in relation to online grooming and exploitation. The guideline committee have made a research recommendation on this topic.
NSPCC	Short	17	12	We would like to provide an example of good practice in the assessment of risk and need in relation to abuse and neglect. Graded Care Profile 2 (GCP2) is an NSPCC tool which has been evaluated to find that it helps professionals to identify risks of child neglect and potential harm more effectively and to promote positive change for families. Useful features included the scoring process which helped to quantify neglect and make neglect more visible to professionals and to parents. The Graded Care Profile (GCP) scale was developed in 1995 as a practical tool to give an objective measure of the care of a child across all areas of need where there are concerns about neglect. This showed positive potential through evaluation. The NSPCC worked to remove the limitations of the tool and amended the GCP in various ways, although the core principles remained the same. This resulted in the second version of the tool, known as GCP2. The new iteration has been evaluated thoroughly and been found to be reliable and valid. It can be used in the knowledge that it has sound psychometric properties, and is a reliable and valid assessment tool in aiding practitioners in the assessment of child neglect. GCP2 is currently being piloted in a number of local authority areas, and we would be happy to share our learning and expertise from the assessment tool.	Thank you for your comment. Our main literature search found a qualitative evaluation of the Graded Care Profile tool (Sen et al. 2014) which was included and presented. However, the guideline committee did not consider this sufficiently strong evidence on which to base a recommendation about the tool. Our update literature search was focused on effectiveness studies only. This identified a further study (Johnson et al. 2015) but this was excluded as it did not meet the evidence criteria for the update search. For more information on inclusion and exclusion criteria please see the full guideline document.
NSPCC	Short	23	18	We are pleased that the guidelines recognise the importance of therapeutic support for children who have been abused or neglected, but the recommendations sadly do not match the reality of the current climate. The NSPCC has been campaigning for years for children to receive the therapeutic support that they need following abuse and neglect. We know that every year over half a million children are abused in the UK; the equivalent of two children in every primary school class. The support they receive following abuse can mean the difference between overcoming their trauma, or a life shaped by the horror of their experiences.	Thank you for your comment. We have amended the recommendation in relation to early emotional support (now recommendation 1.6.2) to make it clear that this should be provided by a range of practitioners, with leadership from the social worker involved. The intention of the committee was that this support would be

[2] Radford, L. et al (2011) Child abuse and neglect in the UK today, 47.

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				The recommendation, on page 22 line 21, that early emotional support should be provided for children after abuse and neglect is absolutely something that we support and would like to see available across the country. However, the current system is unable to provide this for the vast majority of children, and without large shifts in funding and commissioning, will not be able to in future. The problems facing these children trying to access mental health support are unsurprising – children aged from 0 to 19 years account for 24 per cent of the population but only receive six per cent of mental health spending.[3] We also know that children who have been abused or neglected are struggling to access the therapeutic support that they need. Child and adolescent mental health services (CAMHS) are struggling to cope with demand – one in five children referred to CAMHS are denied a service, and the average waiting time between referral and assessment ranges from just a week in some areas to more than 26 weeks in others – with an average waiting time of nearly two months.[4] There is no recognition in these guidelines of the likely challenge of enormous waiting lists, nor the real possibility that services will be unable to offer the full length of treatments recommended. The guidelines need to reflect more accurately the current climate of children and young people's social care and mental health services by noting upon the huge challenges that are likely to face practitioners trying to support children in the recommended ways.	provided by those already in contact with the child, rather than a formal therapeutic service. The guideline committee were mindful of the resource constraints on local areas, and made use of cost effectiveness evidence and economic modelling where available, aiming to ensure that implementation of the recommendations would represent good value for money. Where cost-effectiveness evidence or economic modelling was not available, the committee made 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence, as a means of promoting good practice. 'Consider' means that practitioners should think about providing the intervention, rather than that they must offer it. The committee also took in to account the availability of therapeutic interventions. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Given all these considerations, the recommendations were felt by the GC to be aspirational but achievable.
Office for Standards in Education, Children's Services and Skills (Ofsted)	full and short	General		We are concerned that practitioners working in the sectors that Ofsted regulates and inspects will be confused about the status of the new guideline. The full version says on page 4 that the guideline aims to support practitioners by providing evidence based recommendations about what works. However it does not explain to what extent practitioners will be expected to follow these recommendations. Both versions say that practitioners should apply the recommendations 'in light of' their statutory functions and that they should use the guideline 'alongside' statutory guidance, including Working together to safeguard children and Keeping children safe in education. We do not understand what 'alongside' means. Is the guideline intended as an addition to statutory guidance? Or is it good practice but entirely optional? The relationship between the guideline and statutory guidance needs to be explained more fully. This is especially important because in several places the guideline appears to repeat information that is already set out in statutory guidance or expresses the information in a different way. Practitioners need to understand which version of the guidance they are required to follow.	Thank you for your comment. The introductory section now includes more detailed information about the status of the guideline, and its relationship to existing guidance, including Working Together 2015. We have also: - Reviewed the recommendations and removed those which are the same as statutory guidance, and have not been highlighted by evidence as particularly important or not happening in practice - Stated in the introduction to relevant sections what the relevant content in Working Together 2015 are.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short and Full	General		Regardless of the status of the document, the very fact that it is another guidance document that overlaps with statutory guidance will place additional burdens on school staff and practitioners in children's social care.	Thank you for your comment. The aim of the guideline is to support practitioners by making the evidence base accessible through practical recommendations. We have now included more detail in the introduction to the guideline about how this fits with existing guidance.

[3] NSPCC (2016) It's time: campaign report. London: NSPCC.

[4] NSPCC (2016) It's time: campaign report. London: NSPCC.

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Office for Standards in Education, Children's Services and Skills (Ofsted)	Short and Full	General		We understand that this guideline has its basis in previous documents that were aimed at health professionals. But the medical concepts and terminology used are not relevant: it is not possible to 'treat' child protection risks by prescribing the right therapy. The document should place more emphasis on the importance of good social work practice and effective multi-agency work with families.	Thank you for your comment. The committee were aware of the importance of good social work practice, and of searching for and reviewing evidence to support this. In developing the guideline we developed a series of review questions relating to 'aspects of professional practice'. These questions sought to explore professional practices which did not fit easily within the concept of 'an intervention'. There are a number of recommendations relating to good practice in working with children, young people and families. In particular, the principles set out in 1.1 are based on research evidence from children, young people and families, as well as the views of a children and young people's Expert Reference Group who were involved in the process, and aim to capture some of the ways of working with children, young people, parents and carers.In addition to this, the guideline aims to describe interventions and types of support that have been shown to help children families who are at risk of abuse and neglect, or where abuse and neglect has occurred. This is not intended to be a medical model, but rather to support commissioners and practitioners in choosing and delivering the most effective support. Greater clarity about the difference audiences for the guideline has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8,
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short and Full	General		The guideline is long and not easy to navigate. Will NICE be creating an online version with links to the different sections?	Thank you for your comment. There will be an online version of the short guideline, so that practitioners can go quickly to the section relevant to them. There will also be other products in due course, including a shorter 'quick guide' for practitioners and a quality standard. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short and Full	General		The text does not distinguish between actions for practitioners in different roles, who are bound by different statutory responsibilities (such as social workers, teachers, police officers and health professionals). Instead it mostly appears to be advising all practitioners to take the same action. There are some exceptions: for example page 22, line 27 refers to police officers. Elsewhere there are references to 'agencies responsible for planning and delivering services for children' (page 28, line 7) and 'staff working in child protection' (page 29, line 4). The terminology is not consistent and is seldom clear about who should do what. This has the risk of creating confusion among statutory partners about their respective roles and responsibilities for taking action to protect children. More specific wording is needed throughout the document to clarify exactly who should do what.	Thank you for your comment. Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action. Where multi-agency roles and processes are set out in Working Together 2015, we have signposted to this.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short and Full	General		We are concerned about the implication in the guideline that teachers and designated safeguarding leads in schools are responsible for arranging therapeutic interventions for children who need them. Schools do have a role in early help and in supporting multi-agency work with children, but they are not therapeutic institutions.	Thank you for your comment. Additional detail has been added to the introductory text, and in the introductions to sections

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					1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	1	4, 2nd bullet	We question whether the document is really aimed at children and young people. They are not likely to read it and it is not written in language that they will understand.	Thank you for your comment. A separate version of the guideline is being developed for children and young people.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	4	1	Linking to our first comment above, it would help to have a short explanation of what is meant by a 'recommendation'. Is it good practice that has been identified through a review of research?	Thank you for your comment. We have added detail in to the introduction to the guideline about how the guideline has been developed, and the types of evidence used.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	5	24 to 27	The guideline recommends producing a written record of conversations with children and checking that they agree with what is written, for example by asking them to sign the record. We doubt that this is universal practice at present so it may present challenges to practitioners. It would help if the guideline could make clear in what circumstances this should be done.	Thank you for your comment. This recommendation was based on the input of the children and young people's expert reference group, supported by consensus from the guideline committee. We have now clarified in the recommendation that this relates to conversations about abuse and neglect.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	6	10 to 12	We do not know who this paragraph is aimed at or in what circumstances. It seems to imply that a practitioner could be content to allow a situation to continue where a child was vulnerable to abuse.	Thank you for your comment. This recommendation was based on feedback from our children and young people's expert reference group. It is intended to relate to situations in which children and young people are in a place of safety, but may be at some ongoing risk for example, if the abusive parents still pays their phone bill and can monitor their calls.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	7	19 to 23	The distinction between situations when practitioners should 'consider' or 'suspect' child abuse or neglect is confusing. We understand that this terminology is taken from the separate guideline for health professionals about child maltreatment. However, for professionals in children's social care and education, the actions they need to take are not substantially different according to whether abuse is being considered or suspected. Also, the terminology will be unfamiliar to them. We suggest that the risk factors could be listed without labelling them in this way.	Thank you for your comment. The distinction between 'consider' and 'suspect' has been used for consistency with the NICE guideline on child maltreatment. Additional information has been included about the definition of consider and suspect, and the associated actions.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	8	9	It is odd language to talk about 'questioning' children. Is this section aimed at police? If not, softer language such as 'talking to children' would be better.	Thank you for your comment. The wording has been amended to 'asked'.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	8	17	This line recommends that practitioners 'avoid causing possible prejudice to any formal investigation during early conversations about neglect and abuse with children and young people'. Could the guideline explain how practitioners can do that while at the same time putting the needs of the child first?	Thank you for your comment. For more detail we have directed practitioners to the Ministry of Justice's Achieving best evidence in criminal proceedings, which sets out how to work with children and young people without prejudicing formal investigations.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	8	27	The meaning of this sentence is not clear: does this mean that the higher number of carers for disabled children increases the risk?	Thank you for your comment. This recommendation has been amended to remove reference to multiple carers.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	9	3 to 20	This section does not acknowledge that it is the impact of these parental risk factors on children that needs to be assessed. For example, the presence of parental substance misuse and mental health problems may increase the risk of harm, but there are many parents with these problems who manage to parent appropriately. The section should also explain that it is often the interplay of these factors that result in abuse.	Thank you for your comment. We have added a recommendation regarding the interaction between risk factors.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	14	12 to 23	Some of the factors listed in this section are clear indicators of emotional abuse, rather than factors that might lead practitioners to 'consider' that harm might be taking place. So in this section the distinction between 'consider' and 'suspect' is a false one and not helpful to practitioners (see our comment 8 above).	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment, because the committee thought that these indicators were potentially relevant to a wide range of practitioners. The judgement that this is a 'consider' recommendation was made by the committee for the NICE guideline on child maltreatment and reflects the strength of the evidence underpinning these indicators. Reference

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					to exposure to domestic violence and abuse has been removed from this recommendation (now 1.3.31).
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	16	9	We are not clear who this section is aimed at, given that the document is for use by practitioners.	Thank you for your comment. We have made clearer in the introduction to the document that commissioners and managers are also considered to be audiences for the guideline. Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	16	17	Who would complete the standardised questionnaire and why?	Thank you for your comment. Reference to the screening questionnaire has been removed on advice from the guideline committee that no standardised questionnaire is currently available in primary care.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	16	18	What is meant by giving practitioners access to a social worker?	Thank you for your comment. This has been amended to 'providing practitioners with advice on how to make a referral to social care'.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	16	19	The statutory guidance Keeping children safe in education already makes clear that all staff in schools need to be familiar with its contents. This paragraph could therefore be deleted.	Thank you for your comment. A number of consultation comments have highlighted the importance of showing the links between this guideline and other guidance. We have therefore retained reference to this guidance.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	16	23	This section talks about trafficking 'other than for sexual exploitation', but there is nothing about sexual exploitation itself. This is a strange omission, given how extensive and serious a problem there is with child sexual exploitation. We suggest that this section should be more explicit about all the forms of criminal exploitation that pose risks to children.	Thank you for your comment. We have reworded recommendation 1.3.45 to make clear that children and young peple can be trafficked for sexual exploitation.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	17	5 to 11	This section does not mention that professionals who are concerned a child has been trafficked should refer to children's social care and the police. Neither is there reference to the requirement to refer to the National Referral Mechanism nor does the section make reference to the Modern Slavery Act 2015.	Thank you for your comment. We have added reference to making a referral to children's social care and the police, and to the National Referral Mechanism.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	17	19	Assessments under the Children Act 1989 are a statutory responsibility for social workers, but other professionals can lead early help assessments. This should be made clear.	Thank you for your comment. We have amended the introductory text to the section on assessment to make this clearer.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	17	24	This line suggests that adults should be automatically excluded from assessments if they are thought to be perpetrators or abuse or witnesses in a criminal investigation. We would argue that those adults should be part of the assessment, although of course the primary aim is to safeguard the child.	Thank you for your comment. We have amended the wording of recommendation 1.4.4 to indicate that these adults *may* need to be excluded from investigations, but that this is not automatic, and that practitioners should use their judgement to determine whether an adult should be involved.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	18	1 to 5	This section should include the quality of the significant person's relationship with the child.	Thank you for your comment. This has been added to recommendation 1.4.4.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	18	6 to 10	This section should include the child's attachment and relationship with parents and carers.	Thank you for your comment. We have added reference to observing the relationship with parents and carers, but not attachment as this could imply a specialist attachment assessment.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	18	22	We are not convinced that training in communication skills alone is the way to enable practitioners to identify and interpret signs of abuse and neglect.	Thank you for your comment. This recommendation has now been removed.
Office for Standards in Education, Children's	Short	19	9 to 12	This section duplicates guidance in Working together to safeguard children but does not add anything new. It also omits any reference to the importance of multi-agency working to support effective planning, or reviewing plans to ensure that	Thank you for your comment. This recommendation has been included

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Services and Skills (Ofsted)				progress is made against clear outcomes.	because evidence, including from Serious Case Reviews, suggested that, although it is recommended in guidance, analysis does not always occur effectivey in practice. We have therefore retained this recommendation.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	19	20	We doubt that a home visiting programme would be an appropriate intervention to consider in all cases. Any intervention would have to be based on an assessment of what the family needs otherwise it risks being a waste of resources. For example some parents are not ready or able to access group work. If parents are depressed, or heavily dependent on drugs or alcohol they would need support to address these issues prior to group work. For some parents who have serious issues in bonding with their children they may need one to one counselling to address the underlying emotional issues causing this before group work on parenting would be effective.	Thank you for your comment. We have added recommendations at the beginning of the section on early help (recommendations 1.5.1 to 1.5.3) about assessment, and discussing intervention with families and giving people choice.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	19	21	A wide range of professionals are involved in providing early help, but they will not all be in a position to provide home visits on such an intensive basis. This section needs to specify which practitioners should consider this type of intervention. For example, it would not be possible for school staff to offer this sort of programme.	Thank you for your comment. Recommendation 1.5.16 now aims to clarify that home visiting interventions would only be delivered by professionals trained in those interventions, which would exclude professionals such as teachers.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	19	22	A definition of 'confirmed instances of abuse and neglect' would help here.	Thank you for your comment. Reference to this has been removed as this is covered by the concept of 'parents at risk of abusing or neglecting their children' mentioned in the recommendation above.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	22	4-13	This section overlaps with the statutory guidance Working together to safeguard children, which sets out how the statutory child protection processes should work. It is hard to see what is new or different.	Thank you for your comment. We have reviewed the recommendations in this section and removed those which duplicate Working Together 2015 unless: - We found evidence that this aspect of practice was particularly important - We found evidence that this was not happening in practice.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	23	8 onwards	Suggesting that school staff would be involved in commissioning therapeutic interventions for children is not appropriate. Schools are not therapeutic institutions.	Thank you for your comment. Additional detail has been added to the introductory text, and in the introductions to sections 1.1 (also covers 1.2 and 1.3), 1.4, 1.5, 1.6, 1.7 and 1.8, to make clearer who the audience is for each section, and who should take action. The audience for the recommendations on therapeutic interventions does not include school staff.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	28	11	We do not agree that these forms of abuse are less well recognised than others.	Thank you for your comment. In response to your feedback this recommendation has been reworded to simply refer to 'other' forms of abuse.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	28	16 to 23	This section does not say anything new about partnership working: it simply restates what professionals already know.	Thank you for your comment. This section aims to highlight areas of practice which have been shown by empirical evidence of being as of particular importance, or not always working well in practice. We recognise that these principles are not new. However, the evidence we reviewed, including from Serious Case Reviews, suggested that there are still significant obstacles to information sharing. This recommendation therefore emphasises agencies' duties within Working Together 2015 to remove obstacles to partnership working.

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Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	28	24	Co-locating staff from different agencies is not an easy solution: even if the logistics of relocating staff can be overcome there are still challenges in getting staff to work effectively together. Also, it will never be possible to co-locate all the professionals who are working with a child, such as teachers and health professionals.	Thank you for your comment. In response to your, and others', feedback we have removed reference to co-location as a stand-alone recommendation, but included it within the recommendation relating to information sharing. This aims to highlight that co-location is one means to support information sharing but there are others.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	28	26 to 29	Our experience of targeted inspections on child sexual exploitation tell us that more is needed than effective leadership and a local lead. Partners need take responsibility for their role as a discrete agency, work collaboratively with each other and have a shared understanding of how to tackle child sexual exploitation. Strategic goals must be clearly identified, understood and agreed across agencies, which also must commit resources to tackle child sexual exploitation. There needs to be effective information sharing, profiling of local patterns of offending, training for all staff, shared understanding of how to assess risk, coordination of interventions with children to reduce risk and a comprehensive prevention agenda involving the police.	Thank you for your comment. These recommendations were based on factors identified through empirical research evidence reviewed.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	30	9 to 12	The definition of child sexual exploitation in the guideline is not appropriate. It does not take account of the imbalance of power in child sexual exploitation, that 'exchange' can include prevention of something negative, for example a child who takes part in a sexual activity to avoid harm to a member of their family or themselves. The Department for Education has published a new government definition of child sexual exploitation, which should be used here to avoid confusion.	Thank you for your comment. We have amended the definition of child sexual exploitation to the new Department for Education definition as you suggest.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	30	18 to 19	Statutory guidance simply refers to a child as being anyone under the age of 18. It might be easiest to use that definition here.	Thank you for your comment. We have used these definitions for consistency with the NICE guideline on child maltreatment, which this guideline is linked to.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	37	4	The correct term is Local Safeguarding Children Board (LSCB).	Thank you for your comment. We have removed reference to Local Safeguarding Children Boards in light of the changes made by the Children and Social Work Bill.
Office for Standards in Education, Children's Services and Skills (Ofsted)	Short	37	22 to 28	The lack of information in the guideline about abuse outside the family is disappointing, given what we know about problems of grooming, child sexual exploitation and peer on peer abuse. It would help if the guideline provided links to other resources on those subjects.	Thank you for your comment. We found little evidence that met our criteria relating to grooming, child sexual exploitation or peer on peer abuse. As part of the supporting materials for the guideline, NICE will develop a pathway that will link this guideline to other related guidance.
Office of Social Services Department of Health (Northern Ireland)	Short	32	10	In the revised "Co-operating to Safeguard Children and Young People in Northern Ireland" (2016) we removed 'persistent' from the definition on Neglect in recognition of a number of successful prosecutions for 'single incident' neglect that was extremely harmful or near fatal for the child. We did so in recognition that if the criminal standard (beyond a reasonable doubt) to secure prosecution for 'wilful neglect' could be reached in a case of 'single incident' neglect, then 'persistent' should not be retained as it could have a detrimental effect for a Trust (Authority) seeking to secure a Care Order if the lower threshold of evidence (on the balance of probability) was applied because of retention of 'persistent' in the definition of Neglect.	Thank you for your comment. We have used the statutory definition of neglect for consistency with statutory guidance.

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Office of Social Services Department of Health (Northern Ireland)	Short	33	4	We observe that the definition of a Practitioner as "a professional working with children and young people" requires the individual to hold a recognised 'professional' qualification – thereby excluding staff not qualified to that level and/or volunteers with an agency/organisation. We do not disagree with the definition but there may need to be some commentary to reflect that employing organisations are also expected to have policies, procedures and support structures in place to support non-professionally qualified staff and volunteers to contribute, in keeping with wider organisational requirements, to the effective safeguarding and protection of children and young people from child abuse and neglect	Thank you for your comment. This definition did not intend to imply that all practitioners must have professional qualifications. We have amended the definition of 'practitioner' to 'a person working with children and young people…'
Oxfordshire Clinical Commissioning Group	Full	General	General	The main document is too big and unusable as a practitioner reference document in its current form. It does not provide a useful overview for practical every day work	Thank you for your comment. There is a shorter version of the guideline (54 pages) which is the version NICE would expect pracititoners to refer to. The longer version provides details of all the evidence reviewed for those wishing to know more. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance.
Oxfordshire Clinical Commissioning Group	Full	General	General	It is disappointing that this document does not address or include the useful chapters in the previous editions of Working Together on specific abuse issues.	Thank you for your comment. The recommendations in this guideline are based on a review of empirical research evidence. We have made reference to relevant parts of the current version of Working Together (2015) where relevant.
Oxfordshire Clinical Commissioning Group	Full	General	General	It is not clear who or what it is written for (at times health and other time social services doing assessment). Some of it is about services that should be available/ commissioned – rather than practically how to do things	Thank you for your comment. We The introduction has been updated to make clear there are a number of audiences for this guideline including, as you identify, people working at both strategic and operational levels, and both managers and practitioners. We have also worked to separate recommendations for commissioners from those for senior managers, and for practitioners, where, on reflection, this was more appropriate. For example, see: 1.3.9 and 1.3.10.
Oxfordshire Clinical Commissioning Group	Full	General	General	All the research questions would be better presented in a separate document/ addendum. This will provide a clear distinction between practical applications / a resource for use in practice and recommendations / further work required to promote greater clarity and increased understanding of the topic areas.	Thank you for your comment. It is usual NICE practice to include the research recommendations within the main document.
Oxfordshire Clinical Commissioning Group	Full	General	General	There is not enough emphasis on the need for healthy cynicism and curiosity, (patients, parents and carers don't always tell the truth or provide the full picture). There is a need for professionals to retain a description of the professional curiosity and respectful uncertainty approach, adding reminders to practitioners of their need to sustain an analytical approach to all information sources as they would when making a physical clinical diagnosis	Thank you for your comment. We have added more detail to the sections on recognition regarding how practitioners should seek information when they have a concern about abuse or neglect, including triangulating with other sources of evidence.
Oxfordshire Clinical Commissioning Group	Full	General	General	The emphasis on talking to children and young people seems to give impression that abuse occurs in children old enough to give accounts This does not emphasise enough that very young children are those where most fatal/ serious injuries occur. It also does not provide sufficient information about non-verbal cues from those with communication difficulties.	Thank you for your comment. The section on alerting features (see Section 1.3) is intended to give a series of non-verbal indicators of abuse and neglect, including behaviours that may be displayed by children and young people with communication difficulties.
Oxfordshire Clinical Commissioning Group	Full	General	Chapter 1	There is no mention of referral processes and actions for practitioners in order to get to social care for a section 47 assessment process to begin. Between 1.2 and 1.3 something about report requirements and information sharing principles would be valuable for practitioners using this as a resource guide.	Thank you for your comment. We have now added information in to Section 1.3 regarding when to make a referral.
Oxfordshire Clinical Commissioning Group	Full	26	1.4.7 1.4.8 & 1.4.9	Concerned that the role of fathers is not being recognised and that other cares now are significantly involved in children's lives but only mothers are mentioned	Thank you for your comment. The evidence base for these recommendations is based on trials with mothers only. We have now made clearer in the introductory

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					text that, where interventions are recommended for a specific population, this is based on the evidence. We have also made a recommendation in relation to fathers.
Oxfordshire Clinical Commissioning Group	Full	22	1.2.46	Providing top up training sessions every six months may not provide the best learning opportunities and does not match the intercollegiate competency advice and information. Cross referencing to the requirements to show and demonstrate competence according to the level of practitioner requirement laid out in the intercollegiate guidance would ensure consistency between documents and clarity for practitioners.	Thank you for your comment. We have now included reference to the intercollegiate guidance, and changed the frequency of top up to 12 months.
Oxfordshire Clinical Commissioning Group	Short	General	General	Says it is for children and young people as well but does not appear to be written in child friendly language (I think they may produce separate guidance aimed at the public/young people – usually NICE guidance has a separate document aimed at the public).	Thank you for your comment. NICE will produce a separate document for children and young people.
Oxfordshire Clinical Commissioning Group	Short	General	General	It does not emphasis enough that it should be used in conjunction with the NICE guidance on maltreatment	Thank you for your comment. We have now added reference to this in the introductory text for the short guideline.
[Oxfordshire Clinical Commissioning Group	Short	General	General	There is no mention of referral processes and actions for practitioners in order to get to social care for a section 47 assessment process to begin. Between 1.2 and 1.3 something about report requirements and information sharing principles would be valuable for practitioners using this as a resource guide.	Thank you for your comment. These processes are outlined in Working Together 2015. We have therefore directed practitioners to refer to this.
Oxfordshire Clinical Commissioning Group	Short	General	General	It may be more accurate to call the short version ' An approach to/advice for professionals….' - as the document is not about abuse and neglect – but how professionals should approach it	Thank you for your comment. The guideline has been named according to usual NICE naming convention.
Oxfordshire Clinical Commissioning Group	Short	16	1.2.46	Providing top up training sessions every six months may not provide the best learning opportunities and does not match the intercollegiate competency advice and information. Cross referencing to the requirements to show and demonstrate competence according to the level of practitioner requirement laid out in the intercollegiate guidance would ensure consistency between documents and clarity for practitioners.	Thank you for your comment. We have now included reference to the intercollegiate guidance, and changed the frequency of top up to 12 months.
Oxfordshire Clinical Commissioning Group	Short	20	1.4.7 1.4.8 & 1.4.9	Concerned that the role of fathers is not being recognised and that other carers now are significantly involved in children's lives - only mothers are mentioned	Thank you for your comment. The evidence base for these recommendations is based on trials with mothers only. We have now made clearer in the introductory text that, where interventions are recommended for a specific population, this is based on the evidence. We have also made a recommendation in relation to fathers.
Oxford Health NHS Foundation Trust		General	general	There is some good information within the document, but if it is meant to be a practical working document for staff then its length makes this unworkable. There is a lot of text, perhaps more user friendly lay out would be more helpful for staff? Overall the guidance is rather uninspiring and certainly the short version which after all is what most practitioners may consult is not much help in a practical hands-on way It is uncertain how this guidance is likely to help in a practical way services struggling with very difficult and hard to shift neglect cases although we do understand that it may provide a broader strategic framework They say that guidance is for "children and young people at risk of, experiencing or who have experienced abuse or neglect, and their families and carers". This is really broad and hence the recommendations would need to be quite broad to encompass all of this. Including the research question makes it less user- friendly Point 1.1.5 there is no mention of offering the child a chaperone. 1.3.10 - it's helpful that it is explicitly stated that those conducting assessment in relation to abuse/neglect should have access to specialists with knowledge about these young people's specific needs. This is encouraging. 1.5.2 Should include review of previous involvement 1.5.5 Includes safe accommodation; for health staff this is not within their power. Should it read support to obtain safe accommodation? Also what is the definition of culturally appropriate mental health services? 1.2.46 talks about 6 monthly top up training, in today's climate where staff struggle to keep up to date with mandatory training is this realistic?	Thank you for your comment. Following stakeholder feedback, we have worked to make the short guideline more user-friendly, including setting out which sections are relevant for different audiences. A concise 'quick guide' version of the guideline for practitioners will also be developed. To help people to use the guideline and associated materials, NICE has also developed an online 'hub' for the guideline and supporting materials. This includes links to other relevant NICE guidelines and statutory guidance. Recommendation 1.1.5 aimd to focus on getting consent before touching a young person (rather than issues of consent in general) as children and young people who have been abused may have particular difficulties with being touched. We have not added reference to reviewing previous involvement to recommendation 1.5.2 (now 1.6.1) as this may not be an appropriate action for all practitioners. Reference to safe accommodation has now been removed on the grounds that this is also not within the remit of all the practitioners at whom this recommendation

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				1.3.5 & 1.5.4 talks about providing training in communication skills for talking to children etc these are blanket statement which appear to be for all staff. The guidance needs to be more specific about areas that may require comms skills training, or comms skills should be part of other general training already delivered…..as difficult questions are not always related to safeguarding. 1.6.6 - presumably, child-parent psychotherapy for parents who have abused their children should only be the case if it is deemed 'safe enough' from a Safeguarding point of view. Under reasons why a child might not tell - it doesn't explicitly state that the abuser may be threatening the child. It just says that 'they may be being coerced' It's helpful that the guidance includes a link to the Ministry of Justice's 'achieving best evidence in criminal proceedings'. There isn't much mention, though, as to the effects on a child when going through court proceedings. List of signs that a child might be experiencing abuse doesn't mention complaints of intrusive imagery, regressing to previously achieved developed milestones (e.g. bedwetting when they'd previously been able to stay dry through the night), increased 'clinginess' to parents or carers. When assessing a child or young person, there's no mention that efforts should be made to speak to a child on their own, or that they are given a chance to do so. There should be some guidance to professional to whom the child disclosed should stay involved in the young person's care, at least in the initial stages - the child feels safe enough with the professional to disclose to them, so it would be important for that relationship to continue within the child's care. After disclosure, there should be some reference to guidance to working with trauma/PTSD and what to do during the early stages of that (e.g. just after a traumatic experience has occurred). NICE recommends psychological first aid and the importance of early identification of good social support. When considering therapeutic interventions, there's no mention of the need for a specialist assessment - the assessment section here focuses more on assessment of the abuse, but not of then young person's therapeutic needs. This can also differ depending on how recently the child disclosed the abuse - if the disclosure was more recent, then intervention is likely to look different from disclosure of more historical abuse. Detailed and specialist assessment of therapeutic needs is important. The intervention section focuses more on trauma-focused approaches and psychotherapy (both of which are important), but it should acknowledge that the effects of abuse can be wider than that and specific assessment would help tailor therapy and specific guidelines to their specific needs. The recommendation in relation to provision of psychoanalytic psychotherapy may not always be what the child requires and more general therapeutic approaches rather than formal 'therapy' in this area of work may be more appropriate. individual focused psychoanalytic therapy for girls aged 6-14 is recommended - why not for boys? Why this age group? As a wider point, there is little guidance about what safety or stability within this population actually means and what is needed in order for this to be achieved.	was aimed. Reference to 6-monthly top up training has been removed following consultation feedback, and reference made to the intercollegiate training document. Recommendation 1.3.5 has been removed following consultation feedback. Recommendation 1.5.4 (now 1.6.3) has been amended to cross reference the NICE guidance on domestic abuse. Recommendation 1.6.6 (now 1.7.7) is based on the assumption th this is safe for children. The phrase 'they may be being coerced' was intended to convey threats or other types of pressure that may be put on a child. With regard to children's experiences of court proceedings, the criminal justice and legal system is outwith the scope of this guideline. With regard to signs of abuse, recommendation 1.3.12 refers to nightmares rather than intrusive imagery and recommendation 1.3.13 refers to clinginess. Recommendation 1.4.1 has been reworded to refer to communicating with children and young people without their parent or carer being present. With regard to individual psychoanalytic therapy, the evidence on which this recommendation is based was a study undertaken with girls only. The guideline committee did not think it was appropriate to extrapolate this recommendation to boys. However, recommendations 1.7.17 to 1.7.19 are three possible options for children who have been sexually abused. The options in 1.7.17 and 1.7.18 would be available to boys also. We have included explanatory text at the beginning of this section as to why some recommendations are targeted at a specific population only. Recommendation 1.7.3 has been amended to make reference to basing choice of intervention on assessment.
Oxford University NHS FT	short	7	14-16	is augmented by adding the phrase which appears in the introduction of the full guideline This guideline aimed to build on the recommendations in child maltreatment which provided a summary of clinical features associated with child maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. The current guideline extends coverage of alerting features to those which may be observed by other professional groups, and also covers assessment, early help and response. -either adding this at the beginning of section 1.2 or preferably highlighting it in the introduction to full guideline	Thank you for your comment. We have now clarified the introductory text on alerting features, and what action to take.
Oxford University NHS FT	short	8	7-8	There is a lot of very sensible information about talking to children and young people, but it would be good to include a cross-reference somewhere in section 1.2 that most serious non-fatal or fatal abuse occurs in under 1 year old , hence the importance of considering injuries in that age group particularly carefully, as per the NICE guideline 'When to suspect maltreatment in under 18s'	Thank you for your comment. We have now highlighted child age as a vulnerability factor in Section 1.2.
Oxford University NHS FT		9	4-11	Advice on parental risk factors, which are absolutely correct, but the wording currently used implies that if none of these risk factors apply, you don't need to be worried.	Thank you for your comment. The 'alerting features' set out in Section 1.3 also give practitioners guidance on when they

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					should be concerned about a child or young person.
Oxford University NHS FT	Full	General	General	The document is very long and feels unbalanced moving straight from when to suspect to information for those who will be making assessment under s17/47 or early help and info on how to provide early help – but misses out the practicalities of how and when to make referrals. There will be local variations but something more concrete about what tt do when you consider that these factors exist – even if it is as simple as consul your local procedures; discuss with your line manager/supervisor; ascertain whether and how to refer to local MASH/Childrens social care sort of feels as though it should be in there somewhere. Overall it includes information relevant to practitioners in areas such as health visiting/education/hubs/playgroups etc. but not overwhelmingly relevant to hospital or primary care medical/nursing staff. There is a lot of information that would help someone who really was not sure what to do anywhere near as much as, for example, reading OSCB procedures/website would.	Thank you for your comment. These processes are outlined in Working Together 2015. We have therefore directed practitioenrs to refer to this.
Oxford University NHS FT	Short	General	General	This is the document that most will read and contains the recommendations, there are omissions in the short version that need to be put in. Reading the short version as a stand-alone document, one gets the impression that most abuse occurs to children and young people who are old enough to give an account of themselves and mostly takes the form of emotional abuse/neglect/organised or specific situations eg CSE, trafficking etc. This is because the fact that the guideline is intended to work alongside the previous NICE guideline 'When to suspect maltreatment in under 18s' (which gives lots of appropriate detail about physical abuse) is expressed very clearly in the introduction to the full guideline, but much less clearly in the short guideline.	Thank you for your comment. We have now amended the introduction to the short guideline to make the link with CG89 clearer.
Public Health Wales	Full	General	General	Public Health Wales (PHW) welcomes the opportunity to respond to the Child Abuse and Neglect: Draft Guidance and has collated responses from a wide range of professionals across the organisation. "The guideline which makes recommendations about practice in relation to children and young people (under 18, including unborn babies) at risk of, experiencing, or who have experienced, abuse or neglect and their parents or carers" is viewed as a comprehensive document which is evidence based, and will be a useful tool for practitioners to refer to and utilize when managing concerns relating to Child Abuse and Neglect. However it is interesting that the research has been graded (good-fair-poor) and that research considered to be poor have been included in this draft guidance, whilst other prominent research into Adverse Childhood Experiences (ACE) have been excluded from the guidance.	Thank you for your comment. We selected evidence according to our review protocol and appraised the evidence according to processes set out in the NICE guideline manual. Our searches identified a number of studies related to Adverse Childhood Experiences, but none met our inclusion criteria. In the majority of cases, this is because studies were with adults rather than children and young people. A number of studies did not meet the criteria for study design for the questions relating to indicators (they were not a systematic review or meta-analysis).
Public Health Wales	FULL	GENERAL	GENERAL	The draft guidance refers only to England and its legislation and guidance, and fails to mention legislation in Wales. Whilst the draft guidance does not appear to be in conflict with legislation in Wales, namely the Social Services and Wellbeing (Wales) Act 2014, it would be preferable if there was reference to it, and also the Children Act (1989) and Children Act (2004) which are not mentioned in the draft guidance. It may also be helpful to invite a representative from NHS Wales and other agencies from Wales to be committee members, in order to ensure current and future guidance developed by NICE are inclusive of Wales. With regards to areas which may be difficult or challenging to implement, as already stated the draft guidance does not conflict with current measures undertaken in Wales.	Thank you for your comment. NICE guidance applies to England only, but devolved administrations have arrangements for adopting NICE guidance.
Public Health Wales	FULL	GENERAL	GENERAL	With regards to whether the implementation of any of the draft recommendations have significant cost implications, there do not appear to be any additional costs to Wales, as a direct consequence of the proposals laid out in this draft guidance, as there is no obvious conflict with current Welsh legislation, and all agencies represented on the Regional Safeguarding Children Boards across Wales work together on a Regional and National basis to Safeguard and Protect Children at risk of Child Abuse and Neglect, and manage their resources accordingly.	Thank you for your comment. It is encouraging that there will be no significant cost implications of implementing the guidance.
Public Health Wales	FULL	GENERAL	GENERAL	The guidance appears to see abuse as an event (past or present) rather than potentially a pattern of sub safeguarding threshold behaviours/incidents, which are often highlighted as a concern in findings from Serious Case Reviews	Thank you for your comment. We have now clarified the text in Section 1.3 to

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				(SCR's) and Child Practice Reviews(CPR's) (section 1.1.14 'Critical thinking and analysis').	make clearer that if practitioners observe one of the alerting features, they should seek out further information. This should support them in observing patterns of sub-threshold behaviours as you suggest.
Public Health Wales	FULL	GENERAL	GENERAL	The guidance does not refer to common errors in professional judgement and how to prevent their occurrence, such as seeking out gaps in information, to be mindful of adopting the start again approach to intervention, and also the failure to consider information outside of social work, health, police and education such as carers, neighbours, and other allied professionals.	Thank you for your comment. Theview of the guideline committee was that these issues were covered in the assessment section of Working Together 2015.
Public Health Wales	FULL	GENERAL	GENERAL	There is no also no reference to being aware of and managing 'disguised compliance' when working with parents and carers, 'respectful uncertainty' (section 1.1.12), and also the accumulated risk and harm.	Thank you for your comment. Recommendation 1.1.10 makes reference to 'maintaining professional curiosity'.
Public Health Wales	FULL	GENERAL	GENERAL	It may therefore useful to include further focus on prevention in the guidance, and to draw on the research into Adverse Childhood Experiences (ACE) and in managing and reducing the associated risks to protect and promote the child's health and wellbeing, which would also reduce the likelihood of long term harm.	Thank you for your comment. We screened a number of studies relating to ACE research but none met our inclusion criteria. In the majority of cases, this is because studies were with adults rather than children and young people. A number of studies did not meet the criteria for study design for the questions relating to indicators (they were not a systematic review or meta-analysis).
Public Health Wales	FULL	32	1.6.15	The Child Death Review Programme for Wales's Thematic Review of deaths of children through probable suicide, 2006-2012, made recommendations for the prevention of future deaths. Some of these recommendations are relevant to interventions following abuse. The following recommendation supports section 1.6.15 of the draft guideline: -Healthcare commissioners and providers should ensure that evidence based cognitive behavioural therapy services are available for all children who have suffered sexual abuse, including the non-offending parent. They should also ensure pathways are in place to encourage access to these services. In addition, CBT should also be available for those where no conviction or criminal case occurs so on a self-report basis.	Thank you for your comment. It is encouraging that your research supports the recommendations in this guideline.
Public Health Wales	FULL	34	1.7.4	The Child Death Review Programme for Wales's Thematic Review of deaths of children through probable suicide, 2006-2012, made recommendations for the prevention of future deaths. Some of these recommendations are relevant to wider safeguarding issues and relate to information sharing. Section 1.7.4 in the draft guideline should take into account these recommendations: -There should be a National (All Wales) Child Protection Register to which all Local Authorities contribute which is accessible by relevant services as needed, and emergency departments in particular. -There should be Co-ordination of an All Wales Child Protection Register with Child Protection Plans of other nations.	Thank you for your comment. As noted above, NICE guidance applies to England only, but devolved administrations have arrangements for adopting NICE guidance.
Public Health England	Short	5	24	1.1.6 Produce a written record of conversations with children and young people and check that they agree with these (this could include both of you signing the record). Ensure their words are accurately represented, using their actual words if possible. Comment: What about those CYP who cannot/struggle to read English or are too young to understand what is written? This is acknowledged elsewhere but not here, no practical alternative is offered for practitioners.	Thank you for your comment. This recommendation has been reworded to make reference to alternative formats for those who cannot or struggle to read English.
Public Health England	Short	14	27	1.2.33 and 1.2.34 PHE Comment: This could also be a sign of perinatal mental health problems – in some of the other recommendations where there are other potential causes these causes are listed as needing to be ruled out/addressed, but not here?	Thank you for your comment. We have added a paragraph at the beginning of the section on alerting features highlighting that these features can be similar to behaviour arising from other causes.
Public Health England	Short	15	22	1.2.43 In this section consider adding children who are severely overweight as an additional category (children with a BMI ≥UK90 99.6th centile). "International data suggest that children suffering from severe obesity are at increased risk of ill health and are more likely to suffer from severe obesity in adulthood"[i] Note that child obesity should be considered as part of an overall assessment of the child and family and not in isolation as a symptom of neglect or abuse.[ii]	Thank you for your comment. With regard to obesity as an indicator of neglect – this evidence base was considered as part of the development of NICE's guideline on child maltreatment. The guideline committee for this guideline thought the evidence was insufficiently strong to support a recommendation.
Public Health England	Short	39	General (to section 2)	Section 2: PHE Comment: Some of the research recommendations talk about training/increased awareness among staff groups,	Thank you for your comment. We have changed this to 'practitioners' throughout

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				but sometimes they talk about 'professionals' and others 'practitioners' which is confusing about which staff groups should receive training (s2.3 on honour based violence is a good example – training might be needed for 'professionals' but the outcome is increased awareness for 'practitioners').	except where recommendations have been adopted from the NICE guideline on child maltreatment, or in sections which are NICE standard text.
Public Health England	Full			PHE Comment: The new guidelines would be useful for all practitioners to know of the advised approaches to working with children and young people even if they are not lead professionals to include adult substance misuse services who might not be defined as lead professional or practitioner working with children and young people. The definition should be broader.	Thank you for your comment. We have now broadened the definition of the guideline audience to include all those working with children and young people and, for relevant sections, those working in adult services.
Public Health England	Full	26	1.4.7	ENHANCED TRIPLE programme which it is linked to is for teenagers not 2-7 year olds, it needs a different link.	Thank you for your comment. The correct link has been inserted in recommendation 1.5.9.
Parents of traumatised adopted teens organisation (The Potato Group)	Full	General	general	As an organisation representing the views of 300 plus parents of traumatised adopted teenagers, we feel that the guideline does not go far enough to address the needs of this group of children and young people. Our children and young people have suffered child abuse and neglect. Our children and young people , despite therapeutic provision suffer due to ongoing unresolved trauma and misunderstanding by professionals about how their previous maltreatment and neglect in their 1st families (birth/natural families) affect them. We value the recognition of this by the guideline referring to past and current forms of abuse and neglect . We are also pleased to see a research recommendation about the effective interventions for young people who have been abused or neglected (P40 L22-29 &P41 L1-4).	Thank you for your comment and for your support for the guideline. Section 1.7 also includes a number of recommendations about effective interventions for children and young people who have been abused or neglected.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	4	14	Developmental stage – previously maltreated children will have developmental delay – even during adolescence and into early adulthood. This needs to be recognised by practitioners. How is developmental stage defined? Who will assess this? inadequate assessments could mean practitioners will "diagnose" neglect, abuse and maltreatment based on adopted children's presenting behaviour and treat the adoptive parents in the same way 'any disabilities' - should this be expanded, ie not just disabilities as defined in law but other considerable challenges not classified as disabilities - confabulation, a history of false allegations, etc Our suggestion would be to take disabilities into account in communicating with young people - many of our children and young people have disabilities or neurodiverse conditions like ODD, ADHD, ASD etc which require a different kind of 'taking into account' and we feel this should be indicated here Again with respect to communication needs, traumatised young people may have communication needs which a practitioner is not expecting or for which, no formal diagnosis eg disorganized attachment, ASD, PLI. And trauma in itself will affect a young persons ability to communicate their feelings. The check list of what to provide parents include similar information to 1.1.10 and 1.1.11 since in the case of for example a child who is suicidal, self harming etc the person looking after them as well as the child need to know who to contact in an emergency or who to tell that symptoms are getting worse	Thank you for your comments. Recommendation 1.1.1 is intended to convey that children and young people should be involved as much as is possible for them, given their age and developmental stage (recognising that children's developmental stage may not match their chronological age). It is not intended to imply that this should be used to diagnose abuse or neglect. Recommendation 1.1.2 which refers to 'any disabilities' is intended to focus on communication methods, taking in to account particular difficulties. Recommendations 1.3.1 to 1.3.4 refer to reasons that children and young people may find it difficult to talk about abuse and neglect, including communication difficulties and elements of trauma such as confusion, shame and guilt. Reference to contact details has been added to recommendation 1.1.11.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	6	16 onwards	1.1.12, adding a line that states aiming to build a working relationship with parents/carers should recognise that such parent/carer may be parenting a child that is suffering from past abuse (ie, not the cause), and that, as such, they are not dysfunctional and should be recognised as possibly being knowledgeable about the abuse suffered & effect on the child's behaviours. Not sure how this could be worded though.	Thank you for your comment. We have now added the following text to the introduction to the section on 'Alerting features': Practitioners should also recognise that alerting features may be due to non-recent child abuse or neglect. If the alerting features relate to past child abuse or neglect, but the child or young person is now in a place of safety (for example, in an adoptive family) the child or young person should be assessed to see what support they and their parent, carer, foster carer or adoptive parent need to cope with the consequences of the child abuse or neglect.
Parents of traumatised	Short	7-17	1.2 – 1.3 of Draft	Ensure a thorough understanding of the long term impact of Adverse childhood experiences how this may present in	Thank you for your comment. The

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adopted teens organisation (The Potato Group)				adopted children	introduction to the section on alerting features now highlights the fact that the behaviours described may be due to non-recent abuse or neglect.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	7	8	1.1.13 We would like a specific line to be included to ensure that post adoption workers that know adoptive families and their children and young people's previous maltreatment history are included in coordination.	Thank you for your comment. This recommendation (now 1.1.12) is a broad recommendation applying to all practitioners. Post adoption workers are covered by the overarching term social workers in the audience for the guideline.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	8	6	1.2.1 We would like an additional line to make clear that some children and young people may tell (disclose) abuse and neglect many years after suffering the abuse and neglect. They may talk about it in the here and now but the abuse will more likely be historical (while acknowledging that adopters themselves can be abusive).	Thank you for your comment. We have added a recommendation (1.3.4) stating 'Take into account that when children and young people communicate their abuse or neglect (either directly or indirectly), it may refer to non-recent abuse or neglect.'
Parents of traumatised adopted teens organisation (The Potato Group)	Short	9	9	1.2.9 Please add a line to address adoptive parents (& other carers) suffering from Child/adolescent to parent violence and secondary trauma.	Thank you for your comment. Parents being abused by children are outwith the scope of this guideline. Abuse of parents by children is covered the NICE guideline on domestic violence and abuse.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	12	6	1.2.21 Please add 'Past'	Thank you for your comment. We have added text to the introduction for this section highlighting that alerting features may be indicative of non-recent as well as current abuse and neglect.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	12	10	1.2.22 Please add 'Past'	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment, and is based on the evidence reviewed for that guideline, which did not include consideration of indicators of past abuse. We have added text to the introduction for this section highlighting that alerting features may be indicative of non-recent as well as current abuse and neglect.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	13	22	1.2.29 Please add 'Past'	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment, and is based on the evidence reviewed for that guideline, which did not include consideration of indicators of past abuse. We have added text to the introduction for this section highlighting that alerting features may be indicative of non-recent as well as current abuse and neglect.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	18	10	1.3.3 Please add 'Ensure a thorough history of past abuse and neglect is considered'	Thank you for your comment. Reference to history of abuse and neglect has been added to this recommendation (now 1.3.4).
Parents of traumatised adopted teens organisation (The Potato Group)	Short	18	22	1.3.5 Please add in '.....interpret signs of **past and current** abuse....'	Thank you for your comment. This recommendation has now been removed as it duplicates safeguarding training as set out in Working Together 2015.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	23-27	Sec 1.6	1.6. We would like to see all the things being offered to Foster Carers should also be offered to adoptive families, Special Guardianship, and other scenarios where the child is living in a family which did not initiate the abuse (so for example some step families) We also feel that there is a lack of consistency throughout this section of the draft in terms used to describe all parents and carers of previously maltreated children now safe.	Thank you for comment. The recommendations now use three main categories: - Parents and carers who have been involved in the abuse or neglect - Foster carers (including kinship carers and special guardians) - Adoptive parents. At least one intervention is recommended for each group of carers for different age

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					groups of children. The recommended interventions are based on the available evidence. Wherever possible the guideline committee recommended interventions that had been tested with the particular population in question. We have included explanatory text at the beginning of this section as to why some recommendations are targeted at a specific population only.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	17	17	professionals instead of processionals	Thank you for your comment. This has been amended.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	26&27		The level of detail re children who experience sexual abuse and the therapeutic input to help them to manage ongoing difficulties in the aftermath of the abuse is thorough.	Thank you for your comment.
Parents of traumatised adopted teens organisation (The Potato Group)	Short	General	General	Neglect can be an act of omission it can also be an act of deliberate cruelty. The impact of neglect is far more pervasive than other forms of abuse and has profound effects on the way a child develops both physically, mentally and emotionally. This means a multi disciplinary approach e.g. SALT, physiotherapist, Occupational Therapy, CAHMS, Ed psych working with the child, carer and school would seek to identify and support the provision of therapeutic input to allow the child the resources to achieve and develop. There needs to be recognition that some children cannot remain within a family where the abuse and neglect have been perpetrated. This movement out of the environment -although necessary for the child's safety -is yet another loss, and should be recognised as such. The document does not offer much in the way of guidance to practitioners who are working with children who have been neglected..	Thank you for your comment. The recommendations relating to therapeutic interventions following physical abuse, emotional abuse or neglect (recommendations 1.7.1 to 1.7.16) aim to address the needs of this group.
Parents of traumatised adopted teens organisation (The Potato Group)	Short and Full	General	General	There is an increasing problem of adopted teenagers with past histories of abuse and neglect, making false allegations of abuse by adoptive parents. All professionals in this field need training and should have a strategy to deal with these situations in a joined up professional way, liaising with adoption teams and other agencies, such as the police, to support adoptive families and the young person.	Thank you for comment. Recommendation 1.3.4 that when children and young people disclose abuse and neglect, it may actually refer to non-recent abuse and neglect.
Parents of traumatised adopted teens organisation (The Potato Group)	Short and Full	General	General	Adolescent to parent violence is a major reason for previously maltreated , adopted young people to re – enter care. Although we understand that this area of abuse that previously maltreated young people perpetrate against their parents is under researched and therefore is unlikely to be in this guideline ,to not make mention of this sequelae of maltreatment is not in the best interests of the children and young people, the practitioners managing this or the system as a whole.	Thank you for your comment. As you say, this was not within the scope of this guideline. However, violence from children to parents is covered in the NICE guideline on domestic violence and abuse.
Parents of traumatised adopted teens organisation (The Potato Group)	Short and Full	General 37 40	General 22 & 23 22-26	Previously maltreated children and young people deal with the aftermath of abuse and neglect throughout minority and into adulthood. We appreciate the mention of this at P22 & 23 and in the research recc's at P40 but we would ask NICE to be more thoughtful about acknowledging this within the guideline. Could the guideline not consider seeking further input from NICE (funded by the DfE) to produce a guideline for young adults who have suffered abuse and neglect during childhood ?	Thank you for your comment. As you note, the scope of this guideline was about abuse of children and young people under the age of 18. We will highlight your request for a guideline for young adults in part of NICE's process for determining new topics.
Parents of traumatised adopted teens organisation (The Potato Group)	Short and Full	General	General	We are interested to know why the ACE work is not mentioned in any detail at all and what , if any evidence was used from the Romanian/ UK adoption population research ?	Thank you for your comment. We screened a number of studies relating to ACE research but none met our inclusion criteria. Similarly, we screened research relating to Romanian adoptees but no studies met our inclusion criteria.
Parents Protecting Children UK	Short	4	1.1.1	Please be aware that children & young people with autism spectrum conditions may need special assistance to facilitate this. They may be unable to communicate with an unfamiliar adult, especially a perceived authority figure, such as a social worker or police officer	Thank you for your comment. We have added specific reference to neurodevelopmental disorders to recommendation 1.1.2 which relates to communication.
Parents Protecting Children UK	Short	4	1.1.2	Children and young people with autism spectrum conditions may only be able to participate if they have the reassuring presence of a very familiar person - it may not therefore be in the child or young persons best interests to always exclude all family members. Some children & young people may be selectively mute and to exclude the only people they are able to communicate with may be completely denying them a voice. It is imperative to ensure that all professionals coming into contact with children with diagnosed social communication disorder are fully trained in how to recognize and facilitate the child to communicate.	Thank you for your comment. We have added specific reference to neurodevelopmental disorders and the use of communication aids to recommendation 1.1.2. We have also made reference in recommendation 1.4.6. to the need to have access to people with specialist skils to support assessment of disabled children and young people.

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Parents Protecting Children UK	Short	5	1.1.3	In conversations with children & young people who may have diagnosed or undiagnosed Autism Spectrum Differences & Difficulties - be prepared to understand that they may not make eye contact with the questioner and that they may need to converse with the help of an intermediary - who may be a familiar person or a puppet or a pet. It is vital that the person assigned to work with a child with additional needs is fully trained and is not working outside of their remit. All too often social workers record opinion on whether a child has communication deficits when this is not an area of expertise. It is important to ensure that the child knows whom they are speaking with and why that person is involved with them. It is important when a child records their views with professionals that they are not dismissed.	Thank you for your comment. We have added specific reference to neurodevelopmental disorders and the use of communication aids to recommendation 1.1.2. Recommendation 1.1.6 makes reference to making and agreeing a record of any converations.
Parents Protecting Children UK	Short	5	1.1.4	A children or young person with sensory issues or Autism Spectrum Differences & Difficulties may not be able to tolerate fluorescent lighting and may have difficulties with textures on seating or with perfumes from the interviewers hair or laundry products or with extraneous sounds. A child with social communication difficulties may not be comfortable outside of their home and may need the familiarity of home to be comfortable to speak.	Thank you for your comment. We have added reference to sensory processing issues to recommendation 1.1.4.
Parents Protecting Children UK	Short	5	1.1.5	Be aware that children & young people with Autism Spectrum Differences & Difficulties may experience touch and pain differently- they might find a gentle stroke excruciatingly painful or they may appear unperturbed by a broken nose or limb. Be aware that children with social communication disorders may not be comfortable in medical environments as generally medical environments have many sensory stimuli. Medical environments evoke anxiety in many children with social communication deficits and this should be considered.	Thank you for your comment. We have added reference to sensory processing issues to recommendation 1.1.4. Recommendation 1.1.5 focuses on seeking consent for treatment. We have therefore not added reference to experiences of pain.
Parents Protecting Children UK	Short	5	1.1.6	It's best to record the conversation on a phone or dictaphone to avoid dangers of misrepresentation and so that others can verify that the child wasn't led by the questioner. Police, bus conductors etc now wear body cameras, it is time that all professionals such as social workers were not afraid to record their work as this would lead to evidence based reports rather than opinion. Be aware that some children, especially those with autism spectrum conditions, will say just about anything to get themselves quickly out of an uncomfortable interview situation - including saying things which are untrue or designed to please the questioner.	Thank you for your comment. We have added reference to 'another suitable format' to recommendation 1.1.6 to allow for recording of conversations by Dictaphone or similar. Recommendation 1.3.1 also makes reference to the impact of communication difficulties when children and young people are talking about abuse and neglect.
Parents Protecting Children UK	Short	5	1.1.7	Be aware that this can sound terrifying to the children & young people concerned.	Thank you for your comment. The phrase 'in a way appropriate to their age and understanding' is intended to encourage practitioners to think about the impact of sharing records with children and young people.
Parents Protecting Children UK	Short	6	1.1.8	This is especially important to children & young people with autism spectrum conditions. Trust can be broken easily and for a child with social deficits it can be very difficult to regain trust.	Thank you for your comment. We agree that maintaining trust is an important issue for all children and young people., including those with autism spectrum conditions.
Parents Protecting Children UK	Short	6	1.1.9	This is especially important to children & young people with autism spectrum conditions.	Thank you for your comment. We agree that this is an important issue for all children and young people., including those with autism spectrum conditions.
Parents Protecting Children UK	Short	6	1.1.10	This is especially important to children & young people with autism spectrum conditions but be aware that they may have great difficulties with telephones and especially with telephone answering machines. I know adult autistic tech savvy graduates who still can't leave a message on an answering machine.	Thank you for your comment. Recommendation 1.1.2 makes reference to using a range of communication methods.
Parents Protecting Children UK	Short	6	1.1.11	Don't let them down by being early or late - a child or young person with Autism Spectrum Differences & Difficulties may interpret your promise very literally - so if you say 2.00pm then they may be caught off guard and refuse or be unable to talk at 1.45 and may have given up on you and switched the phone off by 2.15.	Thank you for your comment. We agree that this is an important issue for all children and young people., including those with autism spectrum conditions.
Parents Protecting Children UK	Short	6, 7	1.1.12	Be aware of the effects of poverty - poverty may look like neglect - but it is very different. Be aware that a parent or carer at the end of his or her tether may appear aggressive or defensive - they may just be worn out and whilst needing support, may be sick and tired of fact finding exercises, which take up precious time and effort but provide no immediate relief. Be aware that a parent or carer may have undiagnosed medical conditions which may explain things - e.g. A parent with ME / CFS or Ehlers Danlos Syndrome may have difficulties cleaning or tidying their home - this doesn't make them a bad parent but may mean they need some practical help. Be aware that a parent or carer may have undiagnosed Autism Spectrum Differences & Difficulties which may make them appear difficult to deal with, they may be especially reluctant to engage with professional services, they may not make eye contact, they may have difficulties with using telephones etc etc	Thank you for your comment. We have added a recommendation (1.2.2) relating to the impact of environmental and community factors such as poverty. We have also added reference in 1.1.10 to making adjustments for factors such as parental illness or neurodevelopmental disorders. This recommendation also refers to helping parents to deal with the emotional impact of service invovlement. Recommendation 1.1.11 includes

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				Be willing to accept a parent will rarely tell untruths about the care of their children. As with a child do not let a parent down by recording information and conversations based on the professional opinion rather than fact. Allow parents time to process information. Be transparent with parents, as without transparency there cannot be trust. Do not disregard parents views. Ensure intervention offered is appropriate to families with social communication disorder and ensure that discussions surround interventions are clear. Recognise fear in parents as fear can be recorded as aggression, lack of compliance, defiance etc. Ensure parents requests for information surrounding their case is promptly provided so that they can familiarise themselves with the case. Recognise that parents are not social workers and will have frank discussions with their family.	recommendations to be reliable and available, keep parents informed, and agree any records.
Parents Protecting Children UK	Short	7	1.1.13	Always verify fact, never act on the unfounded speculation of another practitioner who may well be acting beyond their own sphere of experience / expertise, or who may simply be mistaken in an assumption. At Parents Protecting Children UK and in related organisations we see many Child Protection referrals based on erroneous assumptions, false premises and misinformation. Since the change from Statements of Special Educational Need to EHCPs and related directives to 'work together', we have seen a massive rise in Child Protection referrals - many of which begin as risk assessments by a practitioner working in an area which they do not fully understand. This is meaning that many families with disabilities &/or neurological differences are needlessly and damagingly investigated for non existent child abuse or neglect. The time and resources could be better used in cases with genuine need if only practitioners got their facts straight in the first place. Ensure that non factual information is immediatey corrected with all agencies.	Thank you for your comments. Recommendation 1.1.11 refers to professionals being clear about the concerns that have led to their involvement. This should allow families to correct any concerns that are not based on correct information.
Parents Protecting Children UK	Short	7	1.1.14	See response to 1.1.13 above. Be especially careful with referrals which arise from parents attempts to secure Special Educational Needs support in schools - it appears that some cash strapped schools are making social service referrals to avoid having to commit financial resources, which their SEN budget would find difficult. Be prepared to change your stance if the situation demonstrates non factual information and allow the family the right to have accurate information recorded.	Thank you for comment. We did not find evidence relating to referrals being made by parents applying for Special Education Needs support.
Parents Protecting Children UK	Short		1.2.4	Again the best method of recording in a non leading way is to ensure a body camera/Dictaphone etc is used so as fact can be recorded and it is vital that professionals are accountable for their work with children.	Thank you for your comment. We have added reference to 'another suitable format' to recommendation 1.1.6 to allow for recording of conversations by Dictaphone or similar. Recommendation 1.3.1 also makes reference to the impact of communication difficulties when children and young people are talking about abuse and neglect.
Parents Protecting Children UK	Short		1.2.7	Or that their disability may mimic these signs e.g. neglect vs. aversion to new or clean clothes. Some children find these changes so difficult to handle that they will go to great lengths to retain the outgrown or dirty clothes. One parent reports that one of her children would sleep in his school shirt, then put the clean one under his shirt to warm up, so that he could hand me the apparently dirty one to put in the washing without having to change out of the shirt he had become comfortable in.	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes
Parents Protecting Children UK	Short		1.2.8	Also need to consider the possibility that sexual exploitation could be from a peer who is being abused but has escaped the notice of the authorities	Thank you for your comment. There is a separate NICE guideline on sexually harmful behaviour by children and young people.
Parents Protecting Children UK	Short		1.2.9	Take care when dealing with parents of children with autistm their may be undiagnosed social communication disorders making the person appear emotionally volatile. Its also needs to be documented that fear can manifest itself many ways which could be misconstrued as emotionally volatile. Many families will not have had social services intervention prior to allegations.	Thank you for your comment. Recommendation 1.1.10 now makes reference to parental learning disability, and 1.1.11 makes reference to meeting the communication needs of parents.
Parents Protecting Children UK	Short		1.2.10	Chronic parental stress can be caused by interventions which are badly handled and unfounded. First time interventions are very intimidating. Parent may find it difficult to engage with professionals whom are intent on proving	Thank you for your comment. Recommendations 1.1.10 and 1.1.11

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				abuse and are therefore inclined to dismiss or misconstrue parental comments and information. It also must be considered that parents with diagnosed /undiagnosed social communication disorders may find professionals hard to interact with as they may need additional time to process information and may be prone to anxiety and stress. Also need to consider the fact that repeated reports and closures of a case to professionals may mean that it is the professionals who have been responsible for chronic neglect by failing to provide services the family clearly needs. (Financial constraints are a common reason for refusing necessary services)	relate to building good relationships with parents, including taking in to account any neurodevelopmental disorders.
Parents Protecting Children UK	Short		1.2.12	For children with social communication disorders, all of the outlined behaivoural traits can directly lead to their disability. It is very concerning for all carers of children with autism to feel that if they report the recognized symptoms and signs a genuine disability that subsequent children services interventions may be warranted as a result. A child with a sensory deficit can be prone to outbursts, a child with social communication related anxiety may be prone to volatile behaviour. Furthermore if there is a genuine reason for upset as outlined ie parental separation, this should not be a reason for concern. It almost seems as a guilt first innocence later response to issues which could be genuine disability. It also appears that some of these behavioural traits could be attributed to normal development. The examples listed in boxes 1 and 2 are all signs of conditions such as sensory integration difficulties and autism spectrum conditions. It is imperative that that practitioners have received autism awareness training, that this is regularly updated and that when these symptoms present it is essential that a developmental psychologist is consulted and assesses the child at the earliest possible stage in order to avoid the unnecessary and highly damaging effects of an inappropriate child protection investigation. Bear in mind that parents may be in denial about a possible autism diagnosis or, conversely, may bring pressure to bear for additional testing to be carried out because they may have been denied access to diagnostic services or referred to the wrong professional who may not have recognised the child's symptoms. It should be noted that in research carried out for the Department of health in 2013, Kennedy et al. Discovered that the majority of professionals receive only 1 day's autism training, usually as part of a larger module on child development, so may miss symptoms or misinterpret them	Thank you for your comment. We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'As highlighted in the recommendations below, alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to consider the possibility of abuse or neglect as a cause for behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
Parents Protecting Children UK	Short		1.2.13	Again sustained emotional responses could be due to autism, sensory integration deficits, anxiety and it is very unwise to attribute this only to abuse. Therefore, trained professionals in social communication should always take some for of part in assessing the child.	Thank you for your comment. We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'Alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to be curious about behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
Parents Protecting Children UK	Short		1.2.14	These may also be signs of and autism spectrum or sensory disorder. Selective mutism avoidance of eye contact, and day dreaming/easily distracted are all part of social communication disorders, again demonstrating the necessity for professionals whom are able to diagnose social communication disorders being involved at all times during suspicions of abuse. Qualified Speech and Language Therapists, and community paediatricians should play a vital role in assessment. It is also imperative that social communication disorders are ruled out as a priority.	Thank you for your comment. We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'Alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to be curious about behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
Parents Protecting Children UK	Short		1.2.15	If the young person is diagnosed/undiagnosed with social communication disorders, then many of the behaviours outlined could be directly attributed to the lack of support in social situations such as schools, the lack of education of their peers, the stress and anxiety of not being "normal" and finally how is intervention for suspected abuse going to allievate these genuine circumstances. Also bear in mind that schools may be in denial of such issues particularly given the pressure to achieve good OFSTED reports. Schools frequently respond to bullying	Thank you for your comment. We acknowledge that there may be a number of reasons why bullying occurs. The wording 'consider' implies that professionals should gather more information before acting further.

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				complaints by stating "we don't have a bullying problem here" or "how dare you suggest we cannot keep your child safe in our school", and may try to pass blame to parents or carers.	
Parents Protecting Children UK	Short		1.2.18	There are many young carers for whom the need to care for a family member interferes with their essential daily activities because no services, or inadequate services, are available to help the family, especially where it is a parent who is disabled.	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment. We agree that being a young carer is not abuse per se. However, in some instances having responsibilities could lead to the child being at risk of significant harm, which is what this recommendation is intended to alert practitioners to.
Parents Protecting Children UK	Short		1.2.19	ChidIren with social communication deficits find medical assessment extremely stressful and more often than not medical assessment is in an enviroment which is full of sensory stimuli. Medical intervention is all too often quite invasive therefore consideration needs to be given to what could be a very normal response from a child with autism. Consideration needs to be given to the possibility of trust issues with unfamiliar adults. Children are rightly taught to be wary of unfamiliar adults, and the presence of a name badge should not be considered reason enough for the child to submit to an uncomfortable situation or examination without objection. In particular children on the autistic spectrum may become extremely distressed in such a situation, not because of abuse, but because they find the situation distressingly uncomfortable	Thank you for your comment. The evidence reviewed for the NICE guideline on child maltreatment from which this is taken suggested that this behaviour can be an indicator of abuse and neglect. The wording 'consider' implies that professionals should gather more information before acting further.
Parents Protecting Children UK	Short		1.2.21	There are a number of genuine conditions which may cause a child to behave in a sexually precocious manner. A previous head injury, Williams Syndrome and autism may all cause a pre-pubertal child to exhibit precocious sexualised behaviour and inquisitiveness.	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes.
Parents Protecting Children UK	Short		1.2.22	Consider that sexual education programmes in primary schools may be poorly delivered. Particularly for a child who is a literal thinker, if care is not taken to stipulate that sexual activity occurs between adults, the child may try to engage in sexual activity with a close friend or sibling because their understanding is that this is what people who love each other do, as a result of their PSHE lessons.	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes
Parents Protecting Children UK	Short		1.1.23	Ensure all medical reasons are ruled out prior to instigating investigation. It is common in autistic children who find sharing difficult, to smuggle away and hide food items, even though food in the household is plentiful. For example they may consider that having to be restricted to one or two chocolate biscuits from a packet so that everyone in the household gets fair shares is unfair to them because they want more than this, and so steal the packet before anyone else gets chance.	Thank you for your comment. The recommendation (now 1.3.23) refers to this behaviour being observed 'with no medical explanation'.
Parents Protecting Children UK	Short		1.1.24	Consideration needs to be given to the parents physical health and ability to manage the home environment. A parent with health or disability issues is not neglectful but may need assistance to manage the home.	Thank you for your comment. The recommendation (now 1.3.24) refers to aspects of the home that are 'in the parents or carers' control'.
Parents Protecting Children UK	Short		1.1.25	Consideration must be given to the fact that a child with autism or sensory issues may have an aversion to transitions, including those between hot/cold, clean/dirty, wet/dry, and may go to extreme lengths to avoid bathing, changing clothes brushing teeth/hair. These issues are more likely to be a sign of their autistic traits than a sign of abuse, especially if other children in the household are normally clean and well dressed. Consideration should also be given to whether the parents may have sensory issues which make it difficult for them to detect that the child is smelly, or to be able to see that clothing is subtly stained	Thank you for your comment. The evidence reviewed for the NICE guideline on child maltreatment from which this is taken suggested that this behaviour can be an indicator of abuse and neglect. The wording 'consider' implies that professionals should gather more information before acting further.We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'Alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to be curious about behavioural and emotional alerting features, even if they are seemingly explained by another cause.'

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Parents Protecting Children UK	Short		1.2.29	Social communication deficits need to be considered first for delayed language. It would be right and correct to ensure all medical known reasons for language delay are considered as a priority	Thank you for your comment. The recommendation (now 1.3.29) refers to poorer than expected language abilities not explained by other factors, such as neurodevelopmental difficulties.
Parents Protecting Children UK	Short		1.2.30	An autistic child may simply be embarrassed to show affection in front of those beyond their immediate family. Especially when they are tired (e.g. At the end of the school day) an autism spectrum child may just want the world to go away and leave them in peace. They need to exclude parents and siblings until they've recovered from over stimulation - they have nothing left with which to be polite and think that their parents should be the first to recognise this and should not be subjecting them to any form of activity or assessment including strangers. They may therefore be very angry with their parents for allowing a stranger or assessor to be present at this time. It needs to be considered that a child with social communication deficits may often hide their feelings until a safe environment. This is well known and documented. Again rather than suspecting abuse, perhaps social communication function could be looked at prior to allegation of abuse.	Thank you for your comment. The evidence reviewed for the NICE guideline on child maltreatment from which this is taken suggested that this behaviour can be an indicator of abuse and neglect. The wording 'consider' implies that professionals should gather more information before acting further.We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'Alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to be curious about behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
Parents Protecting Children UK	Short		1.2.31	The only aspect of this point to be picked up upon is that a child with social communication disorder may choose not to socialize and may withdraw from social activities as a self chosen method of coping. Therefore, this point needs to be consider. Consideration must be given to the fact that a child on the autistic spectrum or with sensory difficulties may find social activities stressful, and enforced socialisation before the child is ready can actually be harmful to them. Failure to provide social activities may be a protective rather than abusive measure. Similarly a child who has extreme reactions to the world around them may actually be the cause of difficulties in the home so may not actually be being scapegoated. A child who is being bullied in school may be the only one in the household coming home and smashing the house up, stealing comfort food etc, this is not a sign of neglect or abuse at home and the child may be unable to verbally communicate the experiences they are enduring in a school or other external environment. Just because a school says there is no bullying going on does not mean that this is not the case.	Thank you for your comment. The evidence reviewed for the NICE guideline on child maltreatment from which this is taken suggested that this behaviour can be an indicator of abuse and neglect. The wording 'consider' implies that professionals should gather more information before acting further.We have added the following text in to the introduction to the section on 'Alerting features' to make this clearer: 'Alerting features for abuse and neglect can be similar to behaviours arising from other causes, such as other stressful life experiences or neurodevelopmental disorders such as autism. However, practitioners should continue to be curious about behavioural and emotional alerting features, even if they are seemingly explained by another cause.'
Parents Protecting Children UK	Short		1.2.32	The assessment must be carried out in a fair manner. In order to collect information about any individual consent should be sought. It is also vital that fact is recorded and not opinion	Thank you for your comment. Consent requirements differ for different types of abuse, and are covered in Working Together 2015, which we refer to. The recommendations in this guideline are intended to focus on gathering information from children and parents.
Parents Protecting Children UK	Short		1.2.33	When assessing a child at the very least video/audio recording should be made and shared with all parties. This would negate opinion and lead to fact. A childs response should always be taken as fact and opinion should not override. Communicating with children with additional needs should always incorporate relevant professionals ie. Speech therapists, OT, community paediatricians. It is vital that social workers do not operate outside of their remit. A social worker may not have the ability to recognize signs such as sensory over stimulation and record it as behavioural issues or selective mutism as withdrawal for example. It is not a good footing to set guidance which states to not rely on parents for information. This is very sad. A parent is a reliable source and an approach of innocent until proven guilty should be taken not vice versa. A parent who is on the autistic spectrum, diagnosed or not, may appear to be emotionally unavailable or unresponsive in the presence of professionals because of a desire to please the professional, or to give the professional their full attention, this does not mean that the parent is normally unavailable or unresponsive to the child. Kanner noted that parents of autistic children appeared at first sight to be emotionally unavailable, something he termed the "refrigerator	Thank you for your comment. Recommendations 1.1.7 and 1.1.11 refer to sharing reports with children and parents or carers respectively. Recommendation 1.4.6 refers to practitioners being able to work with specialists when assessing disabled children. The recommendation relating to not solely relying on parental reports is based on evidence, including from Serious Case Reviews, that not observing or talking to children and young people directly can lead to children and young

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				parent", however by the early 1960s he had recognised that this was not in fact the case and rejected the theory.	people not being sufficiently protected. Following consultation feedback, Recommendation 1.1.10 now makes reference to parental learning disability, and 1.1.11 makes reference to meeting the communication needs of parents.
Parents Protecting Children UK	Short		1.2.34	It is vital that children with social communication disorders receive adequate support, ie. A familiar person could help, independent not state paid advocates should be provided as a matter of course, speech and language therapists, ot, and community paediatricians should be involved as a matter of course to prevent a wrongful label of abuse.	Thank you for your comment. Recommendation 1.1.2 now makes reference to support for children with communication difficulties arising from any disabilities, for example learning disabilities, neurodevelopmental disorders and hearing and visual impairments, including seeking assistance from specialists if needed.
Parents Protecting Children UK	Short		1.2.35	Training social workers in communication skills is useful, however, it is not a substitute for relevant professionals such as SALT, OT and paediatricians and could allow social workers to operate outside their area of experitise.	Thank you for your comment. Recommendation 1.1.2 now makes reference to support for children with communication difficulties arising from any disabilities, for example learning disabilities, neurodevelopmental disorders and hearing and visual impairments, including seeking assistance from specialists if needed.
Parents Protecting Children UK	Short		1.2.36	It is wrong to consider abuse when a parent wants to accompany a child with social communication deficits either diagnosed or undiagnosed. It is a perfectly normal reaction for a parent to want to be with a child. Perhaps if transparency were obtained, such a mirrored windows, interiew rooms, recorded assessments, parents would be more relaxed about the assessment process either medical or social services.	Thank you for your comment. This recommendation (now 1.3.36) is adopted from the NICE guideline on child maltreatment, and is based on the evidence reviewed by the guideline committee for that guideline.
Parents Protecting Children UK	Short		1.2.38	This is far too broad and needs tightening up.	Thank you for your comment. This recommendation (now 1.3.37) is adopted from the NICE guideline on child maltreatment, and is based on the evidence reviewed by the guideline committee for that guideline.
Parents Protecting Children UK	Short		1.2.40	A person whom is unable to provide adequate care, this point needs to be explained as it is ambiguous. It needs to factor in human rights and disability discrimination. For example a parent on the autism spectrum is not discriminated against merely for having a social communication disorder.	Thank you for your comment. Following consultation feedback, this recommendation has been removed.
Parents Protecting Children UK	Short		1.2.42	Take into consideration that some clinics send out appointments perilously close to the appointment date, so missed appointments may be down to postal problems, not the parent's neglect.	Thank you for your comment. We recognise that there may be many reasons why appointments are missed. However, the evidence suggests that this can be associated with abuse and neglect. The wording 'consider' implies that professionals should gather more information before acting further.
Parents Protecting Children UK	Short		1.2.43	Many of these parameters are and should be parental choice. We live in a society with many different cultures, it should be respected that many parents have grown up in cultures where baby clinics are not necessary or provided therefore, the parent feels more at ease to address their concerns with a GP if the need arises. Perhaps it is time to look at why the state is so intent on scrutinizing, and assessing children at all opportunities and allowing parents to make their own choices about the health of their children. Immunisation, health visitors, screening are not compulsory and should not be used to suspect neglect.	Thank you for your comment. We acknowledge that use of these services is voluntary. However, the evidence reviewed for the NICE guideline on child maltreatment from which this is taken suggested that this behaviour can be an indicator of abuse and neglect. The wording 'consider' implies that professionals should gather more information before acting further.
Parents Protecting Children UK	Short		1.2.44	Particular care needs to be paid to children with connectivity disorders as fragile teeth which are susceptible to chipping and decay is a symptom.	Thank you for your comment. The recommendation (now 1.3.43) is intended to relate to parents seeking treatment for dental caries, rather than the presence of caries themselves.
Parents Protecting Children UK	Short		1.2.45	Take into consideration that parents with a child with additional needs will have taken the time to research the child's condition, and that a dispute with medical professionals over treatment approaches may not constitute neglect, but the legitimate exercise the parents right to choose what is appropriate for their child	Thank you for your comment. We acknowledge that there may be a number of reasons why parents do not seek

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				Again particular care needs to be paid to this point as many parents and carers are and have been subjected to intrusive investigations when there are genuine illness such as EDS. Parents need to be listened to and respected and treated as partners and equals and not the inferior.	medical advice. However, the focus of this recommendation is on when this occurs and the child's health and wellbeing is subsequently compromised.
Parents Protecting Children UK	Short		1.2.46	**These guidelines should point out the differences between social communication deficits and symptoms of abuse/neglect.** The experience of Parents Protecting Children UK and a number of other family support agencies and several groups concerned with specific illnesses and disabilities - especially those which include octal and communication differences or deficits has led us to conclude that many families are ricocheted into Child Protection Proceedings and the Family Courts or the Court of Protection because education, health and social care practitioners confuse social communication differences & deficits with symptoms of abuse. This has been confirmed by small scale research undertaken in 2015/16 by Professor Simon Baron Cohen et al at the University of Cambridge. Primary care workers should be trained to recognise and / or or have access to someone who is trained to recognise social communication disorders.	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders.
Parents Protecting Children UK	Short		1.2.47	All professionals receive regular child protection/safeguarding training, however few receive specific autism awareness training, and this has led to many cases of families being subjected to wrongful and stressful child protection proceedings because of a failure to recognise neurological developmental difficulties. It is therefore essential that all professionals receive regular and extensive training in neurological differences such as autism conditions as well as in safeguarding training.	Thank you for your comment. Recommendation 1.4.6 states that practitioners assessing abuse and neglect of disabled children should be able to work with specialists. Following consultation feedback we have also added reference to accessing specialist support for communicating with children with communication diosrders in to recommendation 1.1.2, and reference to understanding typical and atypical child development to recommendation 1.5.6.
Parents Protecting Children UK	Short		1.3.1	In recent months far too many section 47 investigations have come to light where the children have not been seen and the family were unaware of the investigation until after its completion. Where social communication disorders are diagnosed either in parent or child a qualified speech therapist at the least needs to be involved. Parents and children with social communication disorders often need additional time to process information therefore practitioners without experience may record inaccurate opinion due to lack of processing time.	Thank you for your comment. Recommendations 1.1.2 and 1.1.11 now make reference to meeting the communication needs of children and young people and parents respectively.
Parents Protecting Children UK	Short		1.3.2	Information should be provided accurately and consent obtained from the persons prior to request for such information. Far too often information is shared without consent.	Thank you for your comment. This recommendation relates to a practitioner gathering information from significant individuals in a child's life, rather than when and how that information is shared.
Parents Protecting Children UK	Short		1.3.3	Assessment of the child/young person should be recorded for accuracy purposed. If social communication disorder is diagnosed then said assessment should be carried out by a person fully trained to communicate with a child with additional needs. Speech therapists are under utilized in this area and could potentially resolved many false allegations. Social workers are operating outside of their areas of expertise assessing.	Thank you for your comment. Recommendation 1.1.2 makes reference to the need for all communication with children and young people to take account of any communication needs, including seeking assistance from specialists as needed.
Parents Protecting Children UK	Short		1.3.4	Please see 1.1.13 (copied here for ease of access and because this is such an important point) Always verify fact, never act on the unfounded speculation of another practitioner who may well be acting beyond their own sphere of experience / expertise, or who may simply be mistaken in an assumption. At Parents Protecting Children UK and in related organisations we see many Child Protection referrals based on erroneous assumptions, false premises and misinformation. Since the change from Statements of Special Educational Need to EHCPs and related directives to 'work together', we have seen a massive rise in Child Protection referrals - many of which begin as risk assessments by a practitioner working in an area which they do not fully understand. This is meaning that many families with disabilities &/or neurological differences are needlessly and damagingly investigated for non existent child abuse or neglect. The time and resources could be better used in cases with genuine need if only practitioners got their facts straight in the first place. Ensure that non factual information is immediately corrected with all agencies. We understand that the National Audit Office are shortly to look at the problems with EHCPs.	Thank you for your comment. The committee were mindful of the potential for misidentification of abuse and neglect amongst disabled and neurodiverse children and young people. Recommendation 1.4.6 highlights the need for practitioners conducting assessments to have access to specialist knowledge as part of guarding against this.

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Parents Protecting Children UK	Short		1.3.5	Children with autism should be assessed by a social worker and a professional such as a speech therapist to assist with communication deficits.	Thank you for your comment. Recommendation 1.1.2 makes reference to the need for all communication with children and young people to take account of any communication needs, including seeking assistance from specialists as needed.
Parents Protecting Children UK	Short		1.3.6	Individualised approach should also include involving relevant and qualified persons whom understand and have the necessary experience to understand social communication disorders.	Thank you for your comment. Recommendation 1.1.2 makes reference to the need for all communication with children and young people to take account of any communication needs, including seeking assistance from specialists as needed.
Parents Protecting Children UK	Short		1.3.8	It is important that practitioners stick to the Working Together Guidance on assessment as all too often the focus of social work assessments in negativity and positive attributes within a family are entirely ignored and not recorded.	Thank you for your comment. We have amended the introductory text for section 1.4 to make it clearer that pracititoners should follow the Working Together 2015 guidance on assessment.
Parents Protecting Children UK	Short		1.3.9	A plan whether it be CIN or CP should be discussed with a family and opinion should be sought from said family. Time should be given to the family to process information.	Thank you for your comment. We have added reference to agreeing the plan with the child and their family.
Parents Protecting Children UK	Short		1.3.10	Professionals whom are undertaking assessment of disabled children should be accompanied by a professional whom can recognize and support a child with such a disability. For example if a child on the autism spectrum had a speech therapist present it could assist the child and the accurate recording of information.	Thank you for your comment. This recommendation aims to support the practice you describe.
Parents Protecting Children UK	Short		1.4.1	It needs to be accepted and published that CIN plans are volunatary and that visits from a social worker whom caused a family anxiety may not be welcomed. Particularly in a family with social communication disorders diagnosed or undiagnosed. The right to a private life and the right to a family life needs to be respected. The human rights of any individual should be always prioritized. This would apply to cases where abuse is suspected or disproved.	Thank you for your comment. We have added reference to gaining families' consent, and discussing and explaning to them why you think any intervention may help.
Parents Protecting Children UK	Short		1.4.2	This can appear very intimidating to pregnant mothers and their partners and has to be done in a non judgemental way - which makes the parents feel good about themselves and which must never make them frightened or feel that they are being judged. This is especially important with pregnant women who have been in care and are likely to feel even more that they are being watched. This can be demoralising and make potential success become inevitable failure.	Thank you for your comment. We agree that it is important that support does not appear judgemental or stigmatising. Recommendations 1.1.10 and 1.1.11 set out principles for working with families, including avoiding blame.
Parents Protecting Children UK	Short		1.4.3	It is vital that support packages are agreed with families and families are not subjected to programmes they fundamentally disagree with. Consent again is key, working with a family is paramount. Social communication disorders can account for behaivour in children and social workers are not experts in this area and should never be given the task of educating parents in relation to behaviour connected to diagnosed or undiagnosed social communication disorder.	Thank you for your comment. We have added reference to gaining families' consent, and discussing and explaning to them why you think any intervention may help.
Parents Protecting Children UK	Short		1.4.4	The professional should be relevant to the family i.e. it is not relevant to send a social worker to deal with behavioural issues stemming from social communication disorder.	Thank you for your comment. This recommendation relates specifically to who should deliver the home visiting intervention, and therefore focuses on the skills needed for this role.
Parents Protecting Children UK	Short		1.4.5	Parenting programmes may be irrelevant when dealing with social communication disorder.	Thank you for your comment. These programmes are intended to be aimed at parents who are at risk of abusing or neglecting a child.
Parents Protecting Children UK	Short		1.4.6	Children and adults with autism may not respond well to therapeutic approaches therefore particular attention needs to be paid to the interventions on offer as they may not be relevant or helpful.	Thank you for your comment. Recommendations 1.5.2 and 1.5.3 now makes reference to discussing intervention with families and giving them a choice where possible.
Parents Protecting Children UK	Short	21-23	1.5	CHILD PROTECTION INVESTIGATIONS ARE NOT BENIGN. An erroneous investigation can devastate a family and result in lost social relationships and social status, lost employment, financial hardship, bullying and ostracisation of children. It's vital to get it right in the first place and if the professionals made a mistake and got it wrong then it's vital to	Thank you for your comment. These recommendations aim to support practitioners to carry out assessments and

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				rectify anything and everything possible which can be rectified - eg correcting medical notes, providing proper SEN support, offering financial recompense to help the family move away and start again somewhere where they aren't blamed and labelled for something which was a wrong judgement which took on a life of its own. Parents Protecting Children UK is aware of a number of older teenagers and young adults who are still having social, emotional and educational difficulties as a result of wrongful child protection investigations.	investigation according to best practice.
Parents Protecting Children UK	Short	23	1.6 1-3	Children and adults with autism may not respond well to therapeutic approaches therefore particular attention needs to be paid to the interventions on offer as they may not be relevant or helpful. This is especially true where the only available intervention is psychodynamic in character - autism is not amenable to psychotherapeutic intervention because of the way in which an autism spectrum person views the world.	Thank you for your comment. Recommendations 1.7.1 and 1.7.3 make reference to discussing interventions with children and famiiles, providing choice, and basing interventions on a detailed assessment of the child or young person.
Parents Protecting Children UK	Short	23-27	1.6 4-17	There is a concentration on attachment theory and psychotherapeutic intervention which would be totally inappropriate and unworkable in families with autism spectrum conditions and which don't take into account the complexity of the situation of families with disability and chronic ill health.	Thank you for your comment. We did not find any evidence relating to interventions aimed specifically at families with autism spectrum conditions. Recommendation 1.1.10 refers to making adjustment for factors such as disability and long-term illness.
Parents Protecting Children UK	Short	27-29	1.7	Our experience leads us to the conclusion that the biggest problem is lack of practitioner training to understand disability, neurological difference, mental health difficulties and the complex family problems faced by Young Carers & Siblings.	Thank you for your comment. Recommendation 1.5.6 now makes reference to practitioner training in typical and atypical child development. Reference to neurodevelopmental disorders has been added to recommendation 1.1.2. Recommendation 1.3.18 refers to children with responsibilities that interfere with their essential normal daily activities.
Parents Protecting Children UK	Short	30	Lines 1-5 Attachment (see also several following responses)	Attachment based intervention. This leads to many misunderstandings, false reporting of child abuse and neglect and wrongful separation of parents and children. 1/ Attachment may have been disrupted by social service intervention - if a child is taken away - however temporarily - trust can be broken and need time to be repaired / re-established. It is entirely unfair to judge apparent attachment problems during or following enforced separation of children and parents / siblings.	Thank you for your comment. The aim of the recommended intervention is to support rebuilding of the attachment relationship between parent and child, which may have been impaired for a range of reason.
Parents Protecting Children UK	Short	30	Lines 1-5 Attachment continued. Autism & Attachment	2/ Attachment in families with autism conditions can look 'different' and be misunderstood / misrepresented by practitioners unfamiliar with autism and Asperger's Syndrome. Parents Protecting Children UK saw one report of a very closely bonded, loyal and loving autistic family, in which a psychodynamically trained academic assessor suggested that the children weren't attached to the parent or each other - she couldn't have been more wrong. These were a family who'd been through tragedy trauma and were extremely strongly bonded - but autism and shyness and a desire to protect their privacy prevented them displaying the closeness of their bonds in an intrusive interview conducted by a stranger whom they had no reason to trust. The assessor ensured that both children were taken away from home and placed in separate foster families - with devastating consequences. They needed each other and should have been supported to stay together.	Thank you for your comment. This recommendation does not relate to assessment of attachment, but rather to an intervention to support improvement of the attachment relationships.
Parents Protecting Children UK	Short	30	Lines 1-5 Attachment continued. Bereavement & Attachment	3/ Bereavement plays havoc with family relationships. It is totally unfair and inappropriate to observe and judge attachment in the family of a widow or widower and her / his children during the period when trauma causes numbness - these families need support not judgement. Parents Protecting Children UK has seen at least three bereaved families in which professionals have inflicted further damage by misjudging post bereavement numbness as difficulties with attachment. As I'm writing this, Prince Harry has spoken publicly about how he closed down his emotions following the death of his mother the Princess of Wales. I similarly experienced childhood bereavement and know first hand how hard this is to bear and how long the period of readjustment can be - Prince Harry suggested 20 years. We can now see the close affection between Princes Charles, William & Harry, it is evident in their faces when they are together, but I'm sure that an assessment of attachment in the months and years following the public breakdown of that marriage and tragic sudden death of Diana, would have noticed relationship difficulties which in a less public family could have been misconstrued as attachment failure. 4/ Some families reacting to the traumatic breakup of a relationship (e.g. When one partner has a secret affair and	Thank you for your comment. This recommendation does not relate to assessment of attachment, but rather to an intervention to support improvement of the attachment relationships.

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				suddenly leaves) can exhibit the same symptoms as a family recovering from bereavement by death - and similarly need support and not judgement	
Parents Protecting Children UK	Short	30	Lines 1-5 Attachment & Stranger Danger.	5/ We all rightfully warn our children about 'stranger danger' . To a child who has taken this message to heart any assessor will be perceived as a stranger and therefore as dangerous. The child is therefore likely to be reserved in what they say and demonstrate to the assessor - and this can lead to the assessor misjudging family relationships.	Thank you for your comment. This recommendation does not relate to assessment of attachment, but rather to an intervention to support improvement of the attachment relationships.
Parents Protecting Children UK	Short	30	Lines 1-5 Attachment continued YOUNG CARERS & SIBLINGS	6/ Families with parental or sibling disability or long term illness, and in which the child under scrutiny performs the role of a Young Carer, can be very guarded and self protective and not give effective account / demonstration of their securely attached, complex loving relationships to a stranger who is assessing them. Parents Protecting Children UK has seen at least one case in which a devoted Young Carer was taken away from home, because an assessor had misunderstood and misjudged relationships in the family. The child in this case did not thrive in care.	Thank you for your comment. This recommendation does not relate to assessment of attachment, but rather to an intervention to support improvement of the attachment relationships.
Parents Protecting Children UK	Short	30	Lines 20-23 Disability	Diagnoses change with progress and fashion. It is vital that mental, physical or neurological ability or disability is judged entirely on capability (or lack of capability) and on symptoms - never on labels alone. A few years ago changes to the American DSM meant that some UK children and adults with autism spectrum conditions were re-classified. Some appeared to be upgraded and some downgraded - their symptoms remained the same but the labels changed. The same thing is happening right now to those with Ehlers Danlos Syndrome, Hypermobility and Postural Orthostatic Tachycardia Syndrome. Labels are changing but symptoms are not changing.	Thank you for your comment. We agree that definition of disability should not be based on diagnosis or labels, which is why we selected the Equality Act 2010 definition of disability.
Parents Protecting Children UK	Short	34	Lines 6-10	Because of the similarity to autism of the concerning behaviours and responses of children listed here, priority should be given to training in autism awareness because many families are being subjected to unnecessary, traumatic S47 investigations because practitioners are completely unaware that they are seeing perfectly normal and non-abusive signs autism (diagnosed or not) and not signs of abuse.	Thank you for your comment. Recommendation 1.5.6 refers to practitioners having an understanding of typical and atypical child development, which was intended to cover developmental disorders such as autism.
Parents Protecting children UK	Short	General	General	**For Westminster Forum Child Protection** **Conference Report 23/02/17** In January 2014, I had a phone call from a colleague who keeps better records than I do. *"Have you noticed the rise in medical and autism Child Protection cases?"* *"Yes, its driving me crazy"* *"They all seem to come from a few places."* I Googled the areas she mentioned. *"Oh my goodness, they're the pilot areas for the new Education Health and Care Plans."* *"I knew there had to be an explanation."* *"If these are the trials, then we'll be inundated when EHCPs roll out nationwide in September."* Sure enough, over the past two and a half years things have continued to escalate. Published statistics show rises in Child Protection and Family Court cases over the same time period and various explanations have been given. I think one important reason that's been missed, is the change from Statements of Special Educational Needs to EHCPs, coupled with directives to 'work together'. These changes have led to a rise in education, health and social care practitioners (including unqualified ancillary workers) operating in areas beyond their skills, training, experience, expertise and competence. They 'fail to safety' by making risk assessments, where those assessing risk have little or no knowledge of autism, connective tissue disorders, ME / CFS or a plethora of other difficulties. To the uninitiated these conditions can mimic signs of attachment disorders or abuse. Wrong calls are made and damaging investigations opened into families who are not abusive in any way, but whose children may need special educational, medical or social support. It seems that, although the parents of special needs children may also have special needs, and notwithstanding the	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders.

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				Autism Act 2009, few authorities give Autism Awareness or Complex and Additional Needs training to Social Workers. Cambridge University research has shown that children of autistic women are more likely than others to be investigated for possible emotional abuse. http://bit.ly/2hKAv3s	
Parents Protecting Children UK	Short	General	general	This comment is from a mum, whose family are facing unhelpful professional intervention: *"There is an assumption of competence by professionals of each other. In our county Social Workers are not trained to recognise signs of autism and they will assume abuse when they see those signs. If the parent asks for a referral to get the child assessed, diagnosis will be opposed or blocked on the basis of the Social Worker's professional opinion. The family ends up in the Child Protection system, or even in the Family Courts because the Social Worker misreads the signs, and few parents know enough to ensure that a court appointed expert has appropriate knowledge of autism to correctly appraise what they see.* *Until professionals stop making assumptions of competence of other professionals, we will be stuck in a situation where children with genuine medical needs are regarded as abused by their family and are actually abused by a system that tears them away from loving families and then expresses surprise when they get worse, not better, in a new setting. When it turns out a professional was wrong, no one even apologises to the child or the family for the damage done. That needs fixing before we start assuming we have hundreds of thousands of hidden abused children*." A retired university lecturer in autism replied "*Well put* ". Jan Loxley Blount TCert., Diploma in Child Development.	Thank you for your comment. Recommendation 1.4.6 states that practitioners assessing abuse and neglect of disabled children should be able to work with specialists. Following consultation feedback we have also added reference to accessing specialist support for communicating with children with communication diosrders in to recommendation 1.1.2, and reference to understanding typical and atypical child development to recommendation 1.5.6. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders.
Parents Protecting Children UK	Short	General	General	Parents Protecting Children UK was formed in the aftermath of the 17th October 2001 House of Lords Debate on False and Misleading Accusations of Child Abuse. We serve families with complex and additional needs, who have been caught up in the Child Protection system. Our Facebook community currently has around 1250 followers. https://www.facebook.com/PPPC.UK/ We are currently collating results of a survey which lists Local Authorities who have failed to understand unusual family situations and have reported these as emotional abuse. We work closely with False Allegations Support Organisation, Parents Against Injustice Network and a variety of condition based organisations and family support groups.	Thank you for your comment.
Parents Protecting Children UK	Short	General	General	TIME AND FAMILY CIRCUMSTANCES DIDN'T ALLOW THE THREE OF US WORKING ON THIS DOCUMENT TO COMPLETE IT BY THE DEADLINE - we are therefore submitting it as it is today - aware that there are inconsistencies of style & formatting and that many things remain unsaid. We would be willing to do more if we could be allowed extra time. WE WOULD BE VERY HAPPY TO MEET WITH OTHERS TO EXPAND ON OR EXPLAIN OUR COMMENTS. **We hope that someone with greater awareness of hidden disability, young carers and social communication deficits will be part of the team which finalises this draft as the current draft would cause heartbreak for very many families with disabilities, neurological differences and long term health conditions.** **The current draft would gum up the Family Courts with endless cases which shouldn't be there and would lead to a massive waste of state and local authority resources, which could and should be used to support families in need, rather than to mistakenly investigate non typical families where there is no abuse whatsoever.** **J, L & H 19/04/17**	Thank you for your comment. We have made a number of amendments to the guideline following your and others' comments. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders.We have added reference to accessing specialist support for communicating with children with communication diosrders in to recommendation 1.1.2, and reference to understanding typical and atypical child development to recommendation 1.5.6.
Parents Protecting Children UK	Short	General	General	ABOUT OUR RECENT SURVEY AUTISM, CHILD PROTECTION & MISREPRESENTATION December 2016 COMMENTS MADE PUBLICLY OR PRIVATELY IN DECEMBER 2016 BY INDIVIDUAL PARENTS &/or THEIR FRIENDS &/or SUPPORTERS IN RESPONSE TO A QUESTION ON FACEBOOK BY PARENTS PROTECTING CHILDREN UK ABOUT AUTISM SPECTRUM FAMILIES ACCUSED OF MUNCHAUSEN'S SYNDROME BY PROXY &/or FICTIONAL AND INDUCED ILLNESS &/or EMOTIONAL ABUSE through seeking diagnosis & testing.	Thank you for your comment. We have responded to each of the points made below.

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				This was the question : Parents Protecting Children UK 01/12/16: Autism & Child Protection - There's quite a bit flying around in the ether on this subject at the moment and I wondered if people here could help? If you are an Autism family, or know a family with Autism Spectrum Differences & Difficulties, who have been pulled up on Child Protection concerns, then can you just add the name of the local authority to the list below as a comment. One entry per family. No other information. Comments had not been requested but came on the page, by messenger, by email .... below are a selection collated by Jan Loxley Blount, T Cert. Diploma in Child Development parentsprotectingchildren@live.co.uk https://www.facebook.com/PPPC.UK/ I believe that these comments are highly relevant to the draft guidance as they demonstrate what is already going wrong and what will go wrong even more if this guidance is not edited to differentiate between disability, neurological difference, families with young carers etc and signs of possible child abuse / neglect.	
Parents Protecting Children UK	Short	General		COINCIDENTALLY- DURING THE TIME THAT THIS QUESTION WAS OPEN ON FACEBOOK, THE FOLLOWING ARTICLE APPEARED IN THE GUARDIAN NEWSPAPER - it quotes the campaigner Monique Blakemore of 'Autism Women Matter' and research by Professor Simon Baron Cohen and colleagues at the University of Cambridge.Autism: 'hidden pool' of undiagnosed mothers with condition emerging | Society | The Guardian 26/12/16hî https://www.theguardian.com/society/2016/dec/26/autism-hidden-pool-of-undiagnosed-mothers-with-condition-emerging?CMP=Share_iOSApp_Other	Thank you for your comment. Recommendation 1.1.10 now makes reference to taking in to account parental neurodevelopmental disorders.
Parents Protecting Children UK	Short	General	General	ANONYMISED PARENTAL COMMENTS 1 *"It doesn't seem to make any difference whether mums are diagnosed or not. They just use the diagnosis against mums anyway. The research also shows it's autism families, wether the mum is a Neuro-Typical or Autistic." "The level of ignorance among social workers and other professionals in this area, quite apart from the obvious human cost, must cost the country millions in court and fostering /adoption costs - and every child wrongly taken from their families over autism and similar conditions, is a foster placement that isn't available for a child that genuinely needs one - court time that isn't available to protect a child at genuine risk. " "What I find, is that its the parents who don't have a confirmed diagnosis, but who show traits, who are at greatest risk of being measured against neuro typical standards and expectations. I recommended the book "Child Protection and Parents with Learning Disabilities" to my Local Authority and they purchased two copies!" "So much human cost too. The pain and isolation is unbearable. Not every mother is blessed with the strength to recover and fight back." "Autistic Mothers are being railroaded in the family courts. They are treated appallingly. They are so vulnerable to the predators in child care proceedings who see them as easy targets and abuse their positions. They are totally misunderstood." "This harrowing experience demonises isolates and stigmatises, but in my personal experience provides entertainment and pleasure to many social workers, who really should not be in the profession. I was accused of having Munchausen's Syndrome by Proxy in relation to my younger children, who both have Autism Spectrum Difficulties. The head of service said that she did not want my children further assessed, as it would undermine the Local Authority case against me." "The problem never stopped 'surfacing'. Just its only recently been noticed." "Issues with ..... Council. Is there any parent that would like to contact me to enable us to work together locally?" "Oh God, ... I'm from there. Child Protection cases are happening all the time."*	Thank you for your comment. The guideline committee were cognisant of the issues faced by children, young people, parents and carers with autism. Recommendation 1.1.2 now refers to to tailoring communication methods to disability, learning disability and neurodevelopmental disorder, including seeking assistance from specialists if needed. Recommendation 1.1.4 refers to sensory processing issues in relation to communicating with children and young people. Recommendation 1.5.6 makes reference to pracittioners developing knowledge of atypical child development. Recommendation 1.1.10 now makes reference to taking in to account parental neurodevelopmental disorders.
Parents Protecting Children UK	short	general	general	ANONYMISED PARENTAL COMMENTS 2 *"My friend was also accused and its devastating her. There's three of us in my area. The other has a young child at a special school and her older children are autistic. Social Services are really giving her a hard time." "I am compelled to say that my personal experience of social workers and the lynch mob at Child and Adolescent Mental Health Services is that, any parent who takes the time out to try and learn about the issues that might be making life difficult for their child, is extremely likely to be the subject of attack and hostility - A few years back they had a Doctor working for CAMHS, who nearly killed my child with their unfounded hostility. Had I not gone to seek help at the Court of Protection the Doctor could have caused my child to loose their life. Fight fight fight for your children - but be mindful always that you will likely be attacked yourself." "One Council stole a friend's nephew which the family wanted tested for Autism. The Council Social Services told lies to take him away. They tried saying he was behind, when he wasn't at all. The family just wanted him tested for Autism, which he was showing signs of. The Council blocked the rights of the child*	Thank you for your comment. The guideline committee were mindful of the potential for autism and othe neurodevelopmental disorders to be misdiagnosed as abuse or neglect. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical

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				and family.That is a disgrace. I would like to name and shame the Council Social Services." "I can't believe this is still going on instead of giving families and disabled children the support they need."	cause or neurodevelopmental disorders.
Parents Protecting Children UK	Short	General	General	ANONYMISED PARENTAL COMMENTS 3 *"Let's take away the power of public secrecy, services internalised prejudice and general ignorance. These are what they thrive on in order to make wrong decisions daily and to ruin lives." "It needs exposing quickly , I'm gobsmacked it's happening in our day and age , it's very Victorian / workhouse !" "GPs and paediatricians are so blinkered and unwilling to listen to parents who are genuinely worried with a child with a whole spectrum of weird symptoms and illnesses which are not easily visible." "Lets turn the isolation we feel into positive energy and stop this pain happening to more beautiful families." "I'm glad this issue is gaining recognition. I'm a mother who has been through it and who's autism was the key to survival of it and who succeeded." "I'd be happy to help others in my area." "It's hell!" "Please can you help me? I cannot find any service who will accompany me and be my advocate at meetings! Every service only seems to cover Education Health & Care Plans and nothing else. I have a Looked After Children Review to attend THIS WEEK and have literally only just been told the time of it despite asking for weeks. I am terrified to be in front of the very people who have me in court with false and made up allegations of FII and terrified to even state what I think my child needs in front of them." "AUTISM PARENTS ARE YOU HAVING PROBLEMS WITH SOCIAL SERVICES IN OUR AREA? Such as unwarranted child protection procedures? Solutions may be at hand, unity in numbers. Email me ASAP."*	Thank you for your comments. The Guideline Committee recognised the importance of building good working relationships with parents and carers. They sought to demonstrate this by including a detailed over-arching recommendation about how to do this (1.1.10). This recommendation has been updated post-consultation to include explicit reference to the emotional impact of services' involvement with families. The guideline committee were mindful of the potential for autism and othe neurodevelopmental disorders to be misdiagnosed as abuse or neglect. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders. The Guideline Committee also recognised the importance of ensuring families can access support and advocacy. This is reflected in recommendation 1.5.5.
Parents Protecting Children UK	Short	General	general	*ANONYMISED PARENTAL COMMENTS 4* *"I do have a solicitor but I feel really let down by her. She sat on what had been sent to her and didn't pass it on. She clearly had not looked through it all as she should have pointed things out and chased more evidence!" "The CAMHS service totally failed my child, they wouldn't listen to my concerns around Autism Spectrum Difficulties. After two years of going around in circles I went private and proved my child was Autistic." "How do you ever get over seeing a little lad on a positive adoption photo, when you know his mum is going through hell on earth, its like watching someone being shot in the heart." "I also have 2 friends with SS involvement , just 2 us were put on CP , both off now , 1 is going to court so I've not tagged her in to protect her identity." "We are misunderstood because my child can be violent.". "It just exacerbates a stressful situation. How can we stop it?" "A Child Protection meeting has been convened to decide whether they will put the children on Child Protection plans. They have ignored evidence and not sought any family member's views, ignoring the children's voices." "I have written to my MP about parents being wrongly accused of FII, Munchausen Syndrome by Proxy and emotional abuse. He is looking into this very distressing situation for me and other parents who are trying our best to get medical care or a diagnosis in difficult circumstances. I should be hearing from him soon and will let you know what the outcome is. This includes Autism Spectrum Differences & Difficulties, Ehlers Danlos and other Syndromes. It's an ever growing scandal."*	Thank you for your comments. The Guideline Committee recognised the importance of building good working relationships with parents and carers. They sought to demonstrate this by including a detailed over-arching recommendation about how to do this (1.1.10). This recommendation has been updated post-consultation to include explicit reference to the emotional impact of services' involvement with families. The guideline committee were mindful of the potential for autism and othe neurodevelopmental disorders to be misdiagnosed as abuse or neglect. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether

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					behaviours can be explained by medical cause or neurodevelopmental disorders
Parents Protecting Children UK	Short	General	General	ANONYMISED PARENTAL COMMENTS 5 *"We got our girl back home where she should have always been. I did the application and permission hearing to discharge the SGO. We went through assessments and passed with flying colours. The parenting assessors said she should never have been taken away. At court no one opposed. 5 minute hearing and it was done." "You can include my authority on this list as well. We were on the Child Protection register until a few months ago because of Autism and Ehlers Danlos Syndrome and other medical issues." "I don't want my name coming up in your post about Autism Spectrum Difficulties and Child Protection. Can you add my authority to your list. I have kids with ASD and my ex is possibly ASD and we have been accused and threatened many times- no one understands the complexities of multiple kids with disabilities - now the blame game is on me." "As you know. My friends child was taken by the Council following their false allegations against her devoted mother. The greater good won the day, with the child going back home, though much damaged from the suffering inflicted on her in LA care!! And on and on the sick and twisted authority go!" "As much as I would love to be able to enjoy Christmas, it won't unfortunately be possible. I will put a brave as face for the children, but inside I am in a complete state."*	Thank you for your comments. The Guideline Committee recognised the importance of building good working relationships with parents and carers. They sought to demonstrate this by including a detailed over-arching recommendation about how to do this (1.1.10). This recommendation has been updated post-consultation to include explicit reference to the emotional impact of services' involvement with families. The guideline committee were mindful of the potential for autism and othe neurodevelopmental disorders to be misdiagnosed as abuse or neglect. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders
Parents Protecting Children UK	Short	General	General	ANONYMISED PROFESSIONAL COMMENT ***"Congratulations on getting information on parents of autistic children who have been involved in child safeguarding. The ignorance of social workers never ceases to amaze me - and their ignorance is often accompanied by utter self-confidence that they know it all. Of course some of the children may not even have been diagnosed. yet. The problem is complicated by the fact that females on the autistic spectrum are less likely to be diagnosed, and that mothers of children on the spectrum may also be in that group."***	Thank you for your comments. The Guideline Committee have sought to ensure the guideline reflects the needs of the diverse range of children and young people, and families, who need support. The guideline committee were mindful of the potential for autism and othe neurodevelopmental disorders to be misdiagnosed as abuse or neglect. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders
Parents Protecting Children UK	Short	General	general	*COMMENTS FROM HANSARD* *Parents Protecting Children UK was formed in October 2001 at the time of the House of Lords Debate on False Accusations of Child Abuse.* *The debate was led by Earl Frederick Howe & Lord Tim Clement-Jones CBE* *"**Once the label of child abuse has been attached to a parent it is extremely difficult to remove. Yet we know that there are many hard to diagnose conditions that have been mistaken for parental maltreatment with devastating consequences for families."** Earl Frederick Howe to House of Lords 12 02 03* ***"I am reminded of the witch hunts of previous centuries. This time, the victims are frequently nice middle class families whose only fault is to be concerned about their child, who has ill-defined symptoms from which he or she does not rapidly recover. …, some social workers…..are not prepared to consider that those conditions might be organic."** Margaret, Countess of Mar to House of Lords 17 10 01* ***"The line of cases through Rochdale, Cleveland and the Orkneys must surely convince us all of the dangers. Use by a powerful group of individuals--paediatricians, social workers and the police--of some dubious diagnostic technique or social work theory,…. can lead to massive injustice and family break-up without any***	Thank you for your comments. The Guideline Committee recognised the importance of building good working relationships with parents and carers. They sought to demonstrate this by including a detailed over-arching recommendation about how to do this (1.1.10). This recommendation has been updated post-consultation to include explicit reference to the emotional impact of services' involvement with families

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				objective justification at all."*Lord Tim Clement Jones CBE to House of Lords 17 10 01*	
Parents Protecting Children UK	Short	General	general	LAST WORD FROM ONE OF THE MOTHERS OK, i think I'm done... I do find the emphasis on thinking "abuse" rather than illness, disability, medical condition etc very disturbing and this needs to be addressed, but i'm not sure how... perhaps more emphasis needs to be placed on this as a key part of safeguarding training	Thank you for your comments. The term 'abuse and neglect' has been used in the guideline so that it is consistent with existing guidance related to this topic, in particular, 'Working Together 2015. The guideline committee recognised the importance of building good working relationships with parents and carers. They sought to demonstrate this by including a detailed over-arching recommendation about how to do this (1.1.10). This recommendation has been updated post-consultation to include explicit reference to the emotional impact of services' involvement with families. The guideline committee were mindful of the potential for autism and othe neurodevelopmental disorders to be misdiagnosed as abuse or neglect. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders
Race Equality Foundation	short	5	1.1.6	There is a need to ensure that this equally applies to young people whose first language is not English. It may be worth adding "check that they have understood and agree…"	Thank you for your comment. Recommendation 1.1.6 has been updated as per this suggestion.
Race Equality Foundation	short	5	1.1.7	Same point as in 1.1.6: worth adding: including their understanding of the English language	Thank you for your comment. We have kept this text as it was as, here, 'understanding' is broad, relating not only to language but also, for example, to emotional literacy.
Race Equality Foundation	short	8	1.2.1	Young people in some communities, such as the Asian communities, may also worry that disclosing could lead to them or their family being ostracised by the community.	Thank you for your comment. This particular recommendation is within the section on factors that increase vulnerability to abuse or neglect, rather than likelihood of disclosure. The Guideline Committee did consider young people in different cultural and social contexts when developing the recommendations.
Race Equality Foundation	short	11	1.2.18	How will this be applied to children and young people who are carers?	Thank you for your comment. The Guideline Committee discussed this again post-consultation and agreed this would also apply to children and young people

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					who are carers if their responsibilities caused them to be at risk of, or experiencing, significant harm.
Race Equality Foundation	short	23	1.6	It is worth recognising that therapeutic interventions may be culturally biased and it is therefore imperative that the right intervention with the most appropriate practitioner is used.	Thank you for your comment. This section has been restructured. Recommendations 1.7.1-1.7.3 at the start of this section to make clear that decision-making about intervention choice should include: discussion with, and explanation of interventions and benefits with families; and, recognition that some effective interventions may not suit a particular person or family. This could include, for example, interventions that are not deemed culturally appropriate.
RCGP	Full	8/9		The section relating to section 17 of the 1989 Children's Act and the paragraph starting "Families needing support" needs extensive revision as it is misleading. It should start "Families may receive more intensive support under section 17". Omit that they receive intervention from children's social care services and the reference to previous abuse. Instead write that under section 17 families meet with agencies involved with their care and together they decide what support is needed and who will be able to give this. Omit the rest of the present paragraph because it seems to suggest that all services are available in each locality, that the families are not involved and the professionals don't know what they're doing. The whole point of meeting together is to discuss what is needed and what is available. (GPs often learn a lot and can be part of the solution where there are special needs). Social care services do not need to be involved with section 17 referrals although they will be informed of the results of the meeting. Section 17 is early help before abuse becomes a pattern of coping. GPs can "sell it" to patients that it is a structured way of deciding the help needed and how to give it. Sometimes fostering with a relative maybe be part of the answer and social care is involved then. Education is nearly always involved.	Thank you for your comment. We have redrafted the section to make clearer that families who are assessed under Section 17 of the Children Act will be assessed by a social worker, but may not receive intervention from children's social care as a result. This is distinct from early help, in which the assessment can be conducted by a range of professionals.
RCGP		9	1.2	Other risk factors are household member in prison, and being without both biological parents.	Thank you for your comment. The factors identified are those that the Guideline Committee felt confident highlighting based on the evidence reviewed.
RCGP		15-16	1.6.	"Letting the Future In" is an NSPCC initiative that has been used with some success but is not available universally, as with the CBT groups for those who have been sexually abused. To name poorly evidenced interventions like this seems to be wishful thinking Those who have been sexually abused are often in the position of waiting for years before it is dealt with by the courts if at all and have a legacy of trauma and medically unexplained symptoms. Why not be explicit about this instead?	Thank you for your comment. The guideline aims to be aspirational but achievable and the Guideline Committee considered the recommendation wording in this section to achieve these aims. 'Letting the Future In' is highlighted as an example of an intervention (rather than the only intervention) which delivers the components specified (now 1.7.18).
RCGP		17	1.6	If this course of psychotherapy is recommended, then NHS capacity must become available in every locality. At the moment there is none! Psychomotor psychotherapy evidence has also been claimed.	Thank you for your comment. NICE guidelines describe the most appropriate interventions based on the best available evidence about what works. We have updated the introduction to make clear that, by doing this, it offers commissioners (as well as practitioners) a clear guide to the interventions and approaches that are most appropriate, and represent best value for money, under different circumstances.
RCGP			1.7.4	Suggest that add "Need to know basis" of how much information is shared. This does not mean a summary printout of medical records for example.	Thank you for your comment. Following discussion post-consultation, this recommendation has now been removed on the basis that information sharing is already addressed within Working Together 2015.
Royal College of Nursing	General	General	General	The Royal College of Nursing welcomes proposals to develop this guideline.	Thank you for your comment and support for the guideline.
Royal College of Nursing	General	General	General	We note that while there are lots of innovative practice examples in this field, there is often a dearth of formal evaluation. We are therefore pleased to see that the guideline clearly identifies and articulates areas where there are gaps in the evidence and the need for additional research.	Thank you for your comment and support for the guideline.
Royal College of Nursing	General	General	General	The guideline highlights many challenging areas, including issues in respect of information sharing. Difficulties often	Thank you for your comment. Following

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				arise as a result of interconnectivity between IT systems, organisational boundaries and inter-professional and interagency working. The importance of inter-professional and multiagency training and education is of paramount importance. There are, therefore, serious concerns around frontline health care staff being able to access the right level of education and training needed to ensure they are able to recognise and protect children and young people due to continuing professional development funding cuts, with many organisations relying on staff to access e-learning programmes to acquire and update their knowledge in this area. We note that the guideline emphasises ensuring newly qualified doctors receive training and together with other practitioners in primary care. However, we would argue that all health and social care practitioners regardless of the setting in which they work should have education and training to recognise and safeguard children and young people and that they receive regular updates as set out in the Intercollegiate framework - *Safeguarding children and young people: roles and competences for health care staff (2014)*. There is a particular need to emphasise the importance for those working in areas such as adult mental health, emergency care and sexual health services for example.	discussion post-consultation, the recommendation on information sharing (previously 1.7.4) has now been removed on the basis: that this is already addressed within Working Together 2015; and, the bigger structural issues, such as those you identify, cannot be addressed within this guideline, based on the evidence we reviewed. The Guideline Committee supported the view that all practitioners working with children and young people need to be confident and competent to identify and respond to abuse and neglect. This was a feature of discussions throughout the guideline development process. We have now updated the introduction to make explicit that it is aimed at all practitioners, and also that it complements existing profession-specific guidance.
Royal College of Nursing]	General	General	General	We note that the context in the guideline draws heavily on NSPCC reviews. This is somewhat narrow and would suggest that there are other aspects and resources that could be mentioned here. For example health related research, as well as work undertaken by SCIE or other organisations such as Mental Health Foundation or Centre for Mental Health would be valuable to include. There are significant economic costs which could also be cited.	Thank you for your comment. The Introduction section of the guideline has been revised significantly to take into account consultation feedback.
Royal College of Nursing	General	General	General	The guideline mentions Local Safeguarding Children's Boards. However, these may not exist in many areas in the future in light of the Children and Social Work Bill currently passing through parliament. Consideration should therefore be given to the terminology encompassed within the guideline so that it is not out of date as soon as it is published.	Thank you for your comment. We have now removed all reference to Local Safeguarding Children Boards in light of the Children and Social Work Act.
Royal College of Anaesthetists	Short	General	General	As the Royal College of Anaesthetists, we are delighted to be able to provide some constructive feedback on this draft guideline, the aims of which we fully endorse. We are unable to give professional opinion about its factual content as we are unqualified to do so but we do have some comments as one of the largest Royal Colleges and therefore reflecting a significant number of Doctors working in UK hospitals. We are concerned that the term "Practitioner" is used throughout and may be misleading unless subsequently defined by particular user groups. In a Healthcare setting, will "Practitioner" include all trained members of staff? Using such a wide definition may not be appropriate in all health settings, and particularly where Children and Young People (CAYP) are not the main patient group. The bullet point on page 1 states that the guidance is for "all practitioners" working with children in Health and Social Care, but then suggests thereafter that it is for those for "people in lead professional roles" in services such as education. Can this be more closely defined? In particular the 2014 UK Intercollegiate Child Safeguarding competences suggests that all trained healthcare professionals should achieve and maintain competence at level 2, with those who care regularly for CAYP and/or in a leadership being as a minimum at level 3. Would it be sensible for NICE to reference these well-defined competences?	Thank you for your comment and support for the guideline. The Guideline Committee debated the most appropriate term to use at length,and recognised the complexities you usefully highlight.Practitioner was the preferred term as it was thought to be most relevant to the wide range of professionals to whom the guideline will be relevant. Following consultation, we have added in a definition of lead professional to make clear how this is different, and who would undertake this role. We have also updted the introduction to make clear who the guideline is for and what it offers.
Royal College of Anaesthetists	Short	Section 1.2	46	The recommendation is for 6 monthly top-up training for newly qualified doctors, this seems an unrealistic goal. Firstly newly qualified doctor needs defining, does it mean all doctors in training? Such a schedule of training may be unworkable alongside all of a Junior Doctors learning objectives. Does the requirement for top-up training every 6 months have an evidence base that it is necessary? We feel that this important training should be included into the UK undergraduate medical curriculum and then reinforced within training during the Foundation Years as a minimum for all newly qualified Doctors. Foundation Trusts include Child Protection training in all induction programs for new staff as well as a requirement for yearly appraisal in its permanent staff. Could this training be incorporated in to that schedule?	Thank you for your comment. This recommendation (now 1.3.10) has been updated post-consultation, including to reflect the requirements of existing training frameworks.
Royal College of Anaesthetists	Short	Sections 1.3 – 1.6	17-27	The principles set out are worthy and sensible but many of the sections (1.3, 1.4, 1.5 and 1.6) as well as the research recommendations are very much at Local Authority/ senior safeguarding professional level.	Thank you for your comment and support for the principles. The introduction has been updated to make clear there are a number of audiences for this guideline including, as you identify, people working at both strategic and operational levels, and both managers and practitioners. We have also worked to separate

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					recommendations for commissioners from those for senior managers, and for practitioners, where, on reflection, this was more appropriate. For example, see: 1.3.9 and 1.3.10.
Royal College of Anaesthetists	Short	21	21-25	This section deals with the response once a child protection referral has been made. Whilst it is important to ensure that a case is not lost in the system, it is unrealistic for many practitioners to follow up an individual case in detail. It is also important that time is not wasted by multiple practitioners enquiring at what stage the referral has reached. As the response will likely involve many agencies across e.g. health, education and social care, we would suggest that NICE considers rather recommending that there is better leadership and collaboration between agencies and that time lines for communication are set with all practitioners informed simultaneously e.g. electronically with detail accessible via. a secure and regularly updated information portal.	Thank you for your comment. This has now been removed and, in its place, there is a recommendation that referrals should be made in accordance with NICE Guidline CG89 and local multi-agency safeguarding procedures.
Royal College of Anaesthetists	Short	23	1.6.	The therapeutic models described in section 1. 6 are unlikely to be known to most practitioners in acute health other than those in some areas of Paediatrics, Child Psychiatry and Psychology. We think it would be useful for NICE to indicate within the guidance whose responsibility it is to make recommendations about the most suitable therapeutic care pathway.	Thank you for your comment. We have revised this section, including the introduction, to make clear how decisions about interventions should be made.
Royal College of Anaesthetists	Full	General		This is a very large, wordy document, which at times is difficult to read but it does offer comprehensive guidance to all medical professionals.	Thank you for your comment. We have revised the structure of the guideline, post-consultation. We have worked hard to abbreviate and simplify it, taking into account consultation feedback.
Royal College of Anaesthetists	Full	General		The introduction says that it is aimed at all practitioners working with CAYP. It would seem to be aimed at Safeguarding Leads at all levels and to Social Care, Local Authority, Police colleagues, rather than specialties such as anaesthesia	Thank you for your comment. We have revised the introduction to clarify the audiences and also included a definition of 'lead professional' to make clear how this is different.
Royal College of Anaesthetists	Full	Training		We believe that this is an opportunity to standardise the training in Child Abuse and Neglect throughout the country. Currently most of this training is delivered at Trust level by the local Safeguarding Teams. Commissioning of a national training package would free up expensive resources locally and ensure consistent training is delivered. As already stated setting the frequency of training at 6 monthly intervals may not be applicable to all medical practitioners except those with leadership roles for whom such updates are essential through the peer review process as a minimum.	Thank you for your comment. This recommendation (now 1.3.10) has been updated post-consultation, including to reflect the requirements of existing training frameworks.
Royal College of Paediatrics and Child Health	Full	General	general	Our reviewer asked to consider highlighting different perpetrators or environments as potential risk. For example: in a number of families the behaviour of a sibling is abusive to other siblings both physically, emotionally and through preventing usual participation experiences e.g. going out as a family or at all and preventing having friends home. Throughout document - assumed parent/carers are main perpetrators. Educational experiences, respite provision and other services may be abusive!	Thank you for your comment. We have updated the definition of vulnerability to include social environment. The Guideline Committee were cognisant throughout their discussion that perpetrators could be family members other than parents or carers.
Royal College of Paediatrics and Child Health	Full	General	general	The document does seem to address the specific needs and risks for disabled children and young people well. A small comment: it may be helpful to prompt practitioners to use the expertise of specialist speech and language therapists, as well as workers who know the child or young person well, to support communication when there are special communication needs.	Thank you for your comment and support for the guideline. The Guideline Committee have updated 1.1.6 and 1.3.1 to reflect the need to support specific communication needs, and check young people can understand. They have not specified the practitioners who can support this as they recognised there may be expertise in a number of professionals.
Royal College of Paediatrics and Child Health	Short	1.2.7	Page 8	'Disabled' here and elsewhere should be expanded to 'disabled children and those with special educational needs'	Thank you for your comment. The wording of the recommendations reflect the evidence reviewed.
Royal College of Paediatrics and Child Health	short	Box 1	Page 10	Add 'self-harm' to bullet list	Thank you for your comment. 'Self-harm' is referenced within recommendations 1.3.16 and 1.6.2.
Royal College of Paediatrics and Child Health	short	1.2.29	Page 13	Add 'or has special educational needs particularly learning difficulties.'	Thank you for your comment. The wording of the recommendations reflect the

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					evidence reviewed.
Royal College of Paediatrics and Child Health	short	1.2.31	Page 14	Possibly add 'child treated differently from siblings to its detriment'	Thank you for your comment. The wording of the recommendations reflect the evidence reviewed.
Royal College of Paediatrics and Child Health	Short	general	general	For consistency and clarity, we would recommend that the term 'children and young people' and 'parents and carers' is used throughout the document.	Thank you for your comment. We have reviewed all uses of these terms. These are standardised to 'children and young people' and 'parents and carers throughout except for instances in which law or the evidence dictates otherwise. (For example, recommendation 1.1.5 refers to parents only as parental responsibility is required to give consent for medical treatment).
Royal College of Paediatrics and Child Health	Short	general	general	Young Carers have not been mentioned as a group for health care professionals to be mindful of in relation to child abuse or neglect. Inappropriate caring roles may be carried out by children as young as 3 up to 17 where they are providing emotional, physical or other forms of care such as taking responsibility for medication, discharge plan implementation in the home or paying bills. There is much guidance nationally around the need for improved support and information sharing re young carers, with health being one area to increase identification of hidden carers to then allow the statutory carers assessment (for CYP) to be carried out to identify if there is appropriate or inappropriate care being delivered – this would then lead to a S47 neglect investigation Guidance to consider UN convention on the rights of the child 1989 – A12, A24, A31 Equalities Act 2010 – strengthens support for carers outside of work (shopping, accessing services, using public transport) "planned and coordinated approach for young carers to achieve"– children act 2004, children's plan and children's act 1989 (section 17 "in need" including young carers effective support from social services, education and health) Children and Families Act 2014 / Care Act 2014 – young carers right to an assessment of their needs taking into account education, health and future plans. Working Together 2015 No Wrong Doors 2015 – Memorandum of Understanding between health, children's social care, adult's social care and education. There are three types of assessments for young carers and young adult carers, depending on their age 1. Young carer's assessment for carers under 18 (Children and Families Act Part 5 Section 96 and in line with the Young Carers (Needs Assessments) Regulations 2015) 2. Transition assessment for young adult carers before they are 18 (Care Act 2014 Section 63–65 and following the Care and Support Statutory Guidance) 3. Carer's assessment for all carers aged 18 or over (Care Act 2014) Assessments cover – the caring role, the impact of caring, whether you would like to change your role, health, education, employment, social activities and aspirations for the future There has to be a local independent young carers service. Usually accessed through a CAF or MASH referral.	Thank you for your comment. Young carers were discussed in relation to recommendation 1.3.18 and the Guideline Committee agreed that inappropriate caring roles would be encompassed within this recommendation in relation to children and young people who are carers if their responsibilities caused them to be at risk of, or experiencing, significant harm. Young carers per se would not come within the scope of the guideline, unless they were also experiencing abuse or neglect, either as a result of their caring or role or for another reason. The guideline has been developed based on empirical research evidence, although we have cross-referenced to guidance such as UN Convention on the Rights of the Child, Children and Families Act 2015 and Working Together 2015.
Royal College of Paediatrics and Child Health	Short	4	Page 1	Make reference to other guidance from NICE on patient communication, patient experience	Thank you for your comment. The NICE guidance on patient experience refers to experience of adult services only.
Royal College of Paediatrics and Child Health	Short	Recommendations	Page 4	Make reference to UNCRC	Thank you for your comment. This is now referenced on page 50.
Royal College of Paediatrics and Child Health	Short	1.1.2	Page 4	The ***& Us® RCPCH Voice Bank 2016*** data supports that being clear that communication that supports information and involvement in decision making is key. Our members have stated that for good communication for children and young people (i.e. in this context the long term support of those born pre-term or the support materials provided to siblings or family members) it needs to Be short Be provided on a number of occasions – giving everything at the beginning in written or verbal form can be overwhelming Be in a variety of methods in order to support family sharing (one leaflet doesn't work for everyone) Be mindful of those with English as a second language (e.g. BSL, Polish, Urdu) Be visual with images that support the explanation not just stock photos to make it "friendly" Be making the best use of technology – email, text, WhatsApp, trust apps, websites, video stories of patients and their family experiences, social networks / chats	Thank you for your comment. The Guideline Committee have updated 1.1.6 and 1.3.1 to reflect the need to support specific communication needs, and to check young people can understand. Recommendation 1.3.1 has been updated to make reference to communication needs and not being fluent in English as a barrier to disclosing abuse or neglect. Use of plain language is referenced within 1.1.3.

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				Have language that is accessible	
Royal College of Paediatrics and Child Health	Short	5	1.1 1.1.4.	Make sure the child or young person is comfortable and also keep checking with them at regular intervals	Thank you for your comment. The wording has been updated as per your suggestion.
Royal College of Paediatrics and Child Health	Short	5	1.1.7	As per comment 1.1.2	Thank you for your comment. The Guideline Committee have updated 1.1.6 and 1.3.1 to reflect the need to support specific communication needs, and to check young people can understand. Recommendation 1.3.1 has been updated to make reference to communication needs and not being fluent in English as a barrier to disclosing abuse or neglect. Use of plain language is referenced within 1.1.3.
Royal College of Paediatrics and Child Health	Short	7	1.1.13	This is a view shared in the ***& Us® RCPCH Voice Bank 2016*** support this comment	Thank you for your comment and support for this recommendation.
Royal College of Paediatrics and Child Health	Short	8	1.2 1.1.2	We would recommend that the following key points are included in the list on 'children and young people telling others about abuse and neglect - They may be experiencing coercion if they tell someone about the abuse - They have feelings of confusion about what they are experiencing including feelings of loyalty towards the perpetrator - They may fear that they will not be believed and/or somehow are responsible and will be punished	Thank you for your comment. This recommendation (now 1.3.1) has been updated to include reference to fear of not being believed, feelings of confusion and difficulties communicating. The issue of coercion and not recognising behaviour as abusive or neglectful are already referenced within this list.
Royal College of Paediatrics and Child Health	Short	8	1.2 1.2.7	In reference to risk factors for abuse and neglect, we would also recommend consideration is given to Environmental/community factors (poverty, economic conditions) Parental/individual factors (substance abuse, teen parents) Family factors (domestic violence)	Thank you for your comment. Recommendation 1.2.2 has been included post-consultation to make reference to environmental and community factors. Family factors have also now been separated out 1.2.3-1.2.5. Recommendation 1.3.11 now signposts the reader to the existing NICE guideline on domestic violence.
Royal College of Paediatrics and Child Health	Short	10	1.2 Box 1	We would recommend including a point about lack of social skills and not having many friends, if any.	Thank you for your comment. The details included in this section are based on the evidence reviewed and so this detail has not been included.
Royal College of Paediatrics and Child Health	Short	10	1.2 Box 2	We would recommend including a point about not feeling safe	Thank you for your comment. The details included in this section are based on the evidence reviewed.
Royal College of Paediatrics and Child Health	Short	11	1.2 1.2.15	We would recommend including a point about noting changes in sexual behaviours/intimacy	Thank you for your comment. The details included in this section are based on the evidence reviewed.
Royal College of Paediatrics and Child Health	Short n	18	1.3 1.3.3.	In reference to the second bullet point, we would recommend that the child or young person is seen alone by healthcare professionals	Thank you for your comment. Recommendation 1.4.1 now states that practitioners should communicate directly with children and young people, including without their parent or carer present.
Royal College of Paediatrics and Child Health	Short	19	1.3.9	Need to ensure there is clarity on good quality CYP involvement in this with use of an individual advocate	Thank you for your comment. The original wording has been retained as it makes reference to ensuring the plan is agreed with the child or young person, leaving flexibility for practitioners to achieve this as appropriate, depending on the young person's needs and preferences.
Royal College of Paediatrics and Child Health	Short	22	1.4 1.3.3	When providing support for children and young people after abuse and neglect, we would also recommend that their health and well being is regular monitored by healthcare professional, preferably a specialist doctor such as a	Thank you for your comment. The GC recognised the importance of assessing

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				paediatrician	physical and mental health and wellbeing and, to this end, referenced them explicitly in recommendation 1.6.2,
Royal College of Paediatrics and Child Health	Short	23	1.4 1.5.5.	In reference to the last bullet points, we would also recommend that 'access to healthcare' and 'access to mental health services/support services' is included	Thank you for your comment. The GC recognised the importance of assessing physical and mental health and wellbeing and, to this end, referenced them explicitly in recommendation 1.6.2,
Royal College of Paediatrics and Child Health	Short	21	1.4.11	Need to ensure that support to engage includes advocacy and resource for travel to training and meetings where this could be a barrier	Thank you for your comment. The GC agreed there is a the need to help families identify sources of support, resource and advocacy and have a separate recommendation on this (1.5.5).
Royal College of Paediatrics and Child Health	Short	21	1.4.13	Workers need training on understanding the UNCRC within all areas of their work. Workers also need training in voice and participation on a practical footing – how to do it and how to adapt to needs of the child	Thank you for your comment. It was not possible to specify all components of a training programme, however, the GC sought to emphasise the need to work in a child-centred way by including this in the over-arching recommendations (1.1.1-1.1.9). As a result of post-consultation discussion, the GC also made explicit reference to the inter-collegiate training document (1.3.10) which, in turn, references Working Together 2015. There is also reference to the DfE guidance on Keeping children safe in education. (1.3.9).
Royal College of Paediatrics and Child Health	Short	22	1.5.3 1.5.4	Ensure independent advocacy is included in this support	Thank you for your comment. The GC agreed that advocacy is an important issue, and to address this , highlighted it in a separate recommendation (1.5.5).
Royal College of Paediatrics and Child Health	Short	23	1.5.5	Ensure independent advocacy is included in this support	Thank you for your comment. The GC agreed that advocacy is an important issue, and to address this, highlighted it in a separate recommendation (1.5.5).
Royal College of Paediatrics and Child Health	Short	23	1.5.6	Include CYP in the review to identify if therapeutic interventions have been successful both individually and at a service design level	Thank you for your comment. It is not clear what recommendation your comment relates to (no recommendation 1.5.6).
Royal College of Paediatrics and Child Health	Short	27	1.7	Include CYP in the planning and monitoring of services at a strategic level, as per guidance in legislation UN Convention on the Rights of the Child Statutory guidance for involving young people (issued June 2012 relating to Section 507B of the Education and Inspections Act 2006) Equality Act 2010 Health and Social Care Act 2012 Care Act 2014 Section 242(1B) of the National Health Service Act 2006 as amended by the Local Government & Public Involvement in Health Act 2007 *Section 14z2 = CCGs, Section 13q = NHS England*=	Thank you for your comment. The recommendations in this section are based on the evidence reviewed by the guideline committee.
Royal College of Paediatrics and Child Health	Short	35		This section needs to reference the need to involve CYP as per comment re section 1.7 page 27	Thank you for your comment. Reference to involving children, young people, parents and carers, foster carers and adoptive parents has been added to the section on implementation in the short guideline.
Royal College of Paediatrics and Child Health	Appendices	General	General	As the paediatric educators special interest group we feel it is outside of our remit to comment on cost/resource implications of this guidance, other than to acknowledge the appropriate recognition of the difficulty of increased training in the resource limited setting.	Thank you for your comment. The recommendation relating to training for primary care professionals (1.3.10) has been amended to be more closely aligned to current training arrangements, specifically to reference the intercollegiate training document. .
Royal College of Paediatrics	Short	16	10	Guideline 1.2.46 - Safeguarding is clearly covered by the RCPCH undergraduate curriculum and we feel that this	Thank you for your comment. The

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and Child Health				education should begin as medical students rather than as newly qualified doctors.	recommendation relating to training for primary care professionals (1.3.10) has been amended to be more closely aligned to current training arrangements, specifically to reference the intercollegiate training document.
Royal College of Paediatrics and Child Health	Short	General	General	More generally we commend the clear emphasis on abuse recognition training that this guideline promotes however we would encourage further elaboration on the form that this should take. As this guideline is intended for all practitioners working with children and young people multi-disciplinary professional education is crucial. This encourages professionals to engage with other job roles, learn limitations and feel confident in communicating concern appropriately. Multi-disciplinary education is vital in developing a team culture in which every practitioner feels enabled to act on concerns surrounding abuse and neglect. This also means that they are able to learn to challenge both within their sphere but also other agencies outside their normal scope of practice. We feel that the guidelines lack influence on the importance of clear process and routes of communication for raising concerns if abuse has been recognised. This often varies at a local level but should be a key learning objective for any training on the subject. Only if these are robust and effective will any improvements in recognition be actioned; additionally all practitioners being confident in how to communicate concern is integral to a culture of responsibility amongst all practitioners. Multiple safeguarding training resources are available, 'The Child Protection Practice Manual'1 clearly describes the importance of multidisciplinary education and provides tools for safeguarding training. 1. Hann, G. and Fertleman, C. (2016). The child protection practice manual. 1st ed. Oxford University Press.	Thank you for your comment and support for the focus of this guideline. The GC agreed multi-agency working is a critical success factor, and that there should be opportunities for professionals to leaern together. After discussion post-consultation, they agreed it is important not to replicate what is already in Working Together 2015 and, to this end, have sought to simplify the guideline, so it builds on rather than replicates existing guidance. For this reason, multi-agency training is not referenced in this guideline. Thank you for suggesting Hann & Fertleman's Child Protection Practice Manual for inclusion. However, the review protocols preclude the use of books as sources of data for informing the recommendations, so this book would not be eligible for inclusion.
Royal College of Paediatrics and Child Health	Short	5	24 1.1.6	Children in safeguarding assessments should read and agree the record of their conversation with the professional to whom they are disclosing or reporting maltreatment. This may be difficult eg for a Paediatrician where the report may be prepared / typed after the child has left the consultation but where there is a narrow time frame for the report to be submitted. What if the child discloses maltreatment then withdraws allegation presented as a written report? At what age is a child Gillick competent to understand the significance of signed agreement? And a child may understand that he/she has disclosed but may not have the reading or English skills to understand the implications of a written report.	Thank you for your comment. Recommendation 1.1.5 does not limit pracatitioners to a specific format, recognising that this conversation may happen under a variety of circumstances and that young people's needs can also vary considerably. The GC thought recommendations were aspirational but achievable. Recommendation 1.1.5 now includes details for working with children over and under 16. There is also a definition of Gillick competence included in the Terms used in this guideline section.
Royal College of Paediatrics and Child Health	Short	15	9 1.2.37	" Recognise that excess physical punishment constitutes physical abuse." Guidance needed as to whether any physical punishment is acceptable. Most children referred for suspected physical abuse have a mark or physical sign of injury but the child may be abused without any signs.	Thank you for your comment. Following consultation feedback, this recommendation has been removed.
Royal College of Paediatrics and Child Health	Short	24	7 1.66	" Consider child-parent psychotherapy for parents or carers **and** children under 5 if parent/carer has been physically or emotionally abused or child exposed to domestic violence" Is psychotherapy for the child under 5 ? This must be a misprint and should read "for parents or carers **of** children under 5" ?	Thank you for your comment. The wording is correct as it relates to this intervention being delivered to parents/carers and their children.
Royal College of Paediatrics and Child Health	Short	General	general	Worthy document but where are the resources and provision to provide all the parenting and psychotherapy programmes?	Thank you for your comment and support for this guideline. NICE's remit is to set out the best available evidence on what works. The guideline introduction makes clear that commissioners can use this information to inform their decisions. The guideline committee also took in to account cost-effectiveness evidence in making their recommendations, including economic modelling data where available.

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					Where cost-effectiveness evidence or economic modelling was not available, the committee made 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence. 'Consider' means that practitioners should think about providing the intervention, rather than that they must offer it. The committee also took in to account the availability of therapeutic interventions. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Given all these considerations, the recommendations were felt by the GC to be aspirational but achievable.
Royal College of Paediatrics and Child Health	short	**General**		**Overall, these are excellent and a great example of how to express guidelines succinctly, using everyday language. The section on therapeutic intervention is timely and important. A 'strength-based approach' is used throughout.**	Thank you for your comment and support for this guideline.
Royal College of Paediatrics and Child Health	**short**	**general**		**We cannot comment on the specifics of recommended interventions by either social services or mental health services as we do not know whether there are the resources to provide all the recommended programmes of intervention. This would need to be assessed in detail by practitioners from these services.**	Thank you for your comment. We have had responses from representatives of these organisations. These have highlighted a number of resource impact considerations which we have responded to elsewhere in this document.
Royal College of Paediatrics and Child Health	Short	4	3	Suggest add *What to do if you're worried a child is being abused* (HM Government, March 2015)	Thank you for your comment. Reference to this document has now been added in the introduction to the guideline and in Sections 1.2 and 1.3.
Royal College of Paediatrics and Child Health	Short	5	3-13	Excellent advice on hearing the child's voice, expressed clearly and succinctly	Thank you for your comment and support for the guideline.
Royal College of Paediatrics and Child Health	Short	5	7	Agree with using open questions *but* survivors state that, at times, they wished they had been asked more leading questions. the research question surrounding this which is noted, it is well conceived and expressed. See discussion on 1.2.4 (comment 9) below.	Thank you for your comment. The committee considered this issue carefully, and were particularly mindful of the importance of any conversations not jeopardising any later investigations, as set out in **Achieving best evidence in criminal proceedings**.
Royal College of Paediatrics and Child Health	short	5	24-27	Question 1: It may be impractical for health professionals such as paediatricians seeing a child in relation to possible abuse or neglect to provide a written account of the conversation and allow the child to see it/agree it/sign to verify it. Documenting what has been said in the conversation is not a problem, but the verifying/written agreement of the child might mean the child had to come back for a second meeting so they could agree the doctor's account of what had been said. This would add to the burden on the child. If it was all to be done at the time of seeing the child, it would mean a lot of writing being done while the child was present and would be likely to add to the duration of the process – again an unwelcome consequence of this recommendation. The doctor should check with the child that what the doctor understands to have been said is what the child meant (if age appropriate to do so), but this should not have to be agreed so formally.	Thank you for your comment. Recommendation 1.1.5 does not limit pracatitioners to a specific format, recognising that this conversation may happen under a variety of circumstances and that young people's needs can also vary considerably. The GC thought recommendations were aspirational but achievable.
Royal College of Paediatrics and Child Health	Short	6	6	Unsure what "unrealistic expectations" would be in the context of child safety	Thank you for your comment. This recommendation has been amended and reference to 'unrealistic expectations' removed as it was unclear.
Royal College of Paediatrics and Child Health	Short	6	10	This recommendation may be challenging in terms of advice to practitioners if they need to provide a child or young person with contact details, particularly through phone, email or social media. Good practice guidance might need to be issued by Trusts or NHSE.	Thank you for your comment. The GC considered the recommendations aspirational but achievable. They also

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					sought to be sufficiently broad to encompass the wide range of practitioners working with children and young people, and to allow for flexibility to implement, as appropriate at the local level.
Royal College of Paediatrics and Child Health	Short	8	14	1.2.2 – 1.2.3 are excellent and show good use of everyday language, especially the use of "telling others" instead of 'disclosing'. With respect to 1.2.4., one *might* have to resort to a more leading question style to overcome the child's denial, shame or inability to find words when words have been stolen from him/her. For example, one could say, "I know that this is very difficult for you …. But I know that children in your situation are sometimes being touched in places that feels wrong but that they can't find the words to say it'. 'So, I can say it for you and you can tell me how true that might be for you'. The research question around this issue is noted. Such an approach would not contaminate a 'Best Evidence' interview.	Thank you for your comment. The committee considered this issue carefully and thought that any reference to leading questions would be inappropriate, based on their professional experience of investigation and court proceedings.
Royal College of Paediatrics and Child Health	Short	11	5	Questions 1 and 2: This recommendation on the identifying 'dissociation' in a child might have implications in terms of choosing the right instrument to use and in training professionals on how to use such an instrument or to have the skills to identify dissociation. This is a difficult concept to grasp.	Thank you for your comment. The GC discussed this and considered the explanation provided in brackets to be sufficient.
Royal College of Paediatrics and Child Health	Short	11	11	Suggest adding depression to list	Thank you for your comment. We did not review evidence relating to the association between mental health problems and abuse or neglect, on the grounds that children showing signs of mental ill health would receive treatment and support for this.
Royal College of Paediatrics and Child Health	short	16	14	Questions 1 and 2: Providing top-up training every six months for medical practitioners is likely to be challenging at a time of limited resources within the NHS. It is also likely to be logistically challenging as doctors move posts frequently. In order to achieve 6 monthly top-ups of training, the training would have to be made mandatory. None of the existing mandatory training is delivered at such a high frequency; the most that is required even in areas as important as fire safety is every year. To deliver face to face training of all junior doctors with this level of frequency would be a huge demand on training resources. Making it an on-line training would run the risk of reducing it to a mere tick-box exercise. Consider reducing the frequency to every two years, and it should be a mandatory training on-line module.	Thank you for your comment. We have now included reference to the intercollegiate guidance, and changed the frequency of top up to 12 months.
Royal College of Paediatrics and Child Health	short	16	15	Giving information to new practitioners about local resources is essential for some practitioners but of little benefit to others, depending on the exact nature of their roles. There is no point in giving this information to new junior doctors, for example, as they will not be the doctors making decisions about management of these cases, and they will just be receiving information that is irrelevant to them at a time they need to receive and retain more relevant information.	Thank you for your comment. The guideline recommendations are worded in a way so as to reflect the very broad population of practitioners working with children and young people, and to allow appropriate flexibility in terms of local-level implementation.
Royal College of Paediatrics and Child Health	Short	16	17	Question 1: 'Completing a standard questionnaire to screen for risk factors' in primary care might be difficult to implement: which risk factors do you choose when no one risk factor is necessary or sufficient to predict child maltreatment, and with factors such as alcohol and drug misuse having very high base rates in the community?	Thank you for your comment. Reference to the screening questionnaire has been removed.
Royal College of Paediatrics and Child Health	short	16	18	Not sure to whom access to a social worker is to be provided. Is this for all practitioners? Not clear about what this means.	Thank you for your comment. The wording of recommendation 1.3.10 has been amended following consultation feedback to 'giving practitioners advice on how to make a referral to social care'.
Royal College of Paediatrics and Child Health	Short	18	20	"Reinforce that they have a right to talk about any abuse and neglect". Agree but they might find words and drawing difficult. It is therefore incumbent on professionals to 'feel the child's 'lived experience': what would it be like to be in that child's household? (See also 19.3)	Thank you for your comment. Recommendation 1.4.1 highlights the importance of observation in addition to communicating directly with the child or young person.
Royal College of Paediatrics and Child Health	short	18	22	Questions 1 and 2: Providing training in communication skills to practitioners to enable them to better assess abuse and neglect would be a significant challenge at a time of limited resources across all the agencies. Large numbers of staff would need to be trained in all the agencies and in the third sector, and this would result in a significant cost. It may be more practical to focus only on the staff who will have the biggest role in interviewing children or working with	Thank you for your comment. This recommendation has now been removed as it duplicates safeguarding training as set out in Working Together 2015.

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				them longer term, rather than everyone who encounters children.	
Royal College of Paediatrics and Child Health	Short	19	18 onwards	Questions 1 and 2: There are huge resource implications for Home Visiting Programmes, especially if the recommendation is that they should last at least 6 months. There is also a concern that some families may not engage for that length of time.	Thank you for your comment. The guideline committee considered carefully the cost-effectiveness and resource impact of the recommendations on home visiting. This is a 'consider' rather than an 'offer' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it. However, the committee thought it was important to make this recommendation based on the evidence of effectiveness of many home visiting programmes. Although there was not conclusive evidence of cost-effectiveness, the committee also considered the potential costs of not intervening in families showing possible early signs of abuse and neglect, in terms of the potential for problems to become more serious and to result in greater service use and other costs in the future. The view of the committee was also that many local areas do already offer these interventions, and so there should not be a significant additional cost in implementing these. The recommendation that these should last for 6 months is based on the evidence reviewed by the committee.
Royal College of Paediatrics and Child Health	Short	20	13	Questions 1 and 2: Again, many of these parenting programmes are being decommissioned. Those that are commissioned (Tripe P or Incredible Years) have a sound evidence base but are generally social-learning theory-based and do not reach those where emotional responsiveness is the main concern. Thus, some areas are using programmes such as 'Tuning In For Kids' that, in small trials, can reach carers at risk of harming their children. Any new introduction of such a programme should be subjected to a RCT, against an established programme, using 'social equipoise' (open acknowledgement of uncertainty about effectiveness) as a guiding principle. This will have cost implications but this is where the thrust of early intervention should be, in addition to social and material support (p21, line 4).	Thank you for your comment. The committee considered carefully the evidence on interventions, in the context of their understanding about current practice. The GC agreed there is a gap in research on effectiveness and cost-effectiveness of different approaches to supporting parents and carers and this is reflected in the research recommendations (e.g. 2.10, 2.11, 2.12, 2.13, 2.14 and 2.15).
Royal College of Paediatrics and Child Health	Short	20	15	See comment about page 20 line 13 above	Thank you for your comment. The committee considered carefully the evidence on interventions, in the context of their understanding about current practice. The GC agreed there is a gap in research on effectiveness and cost-effectiveness of different approaches to supporting parents and carers and this is reflected in the research recommendations (e.g. 2.10, 2.11, 2.12, 2.13, 2.14 and 2.15).
Royal College of Paediatrics and Child Health	Short	20	21 and 24	Question 2: Again, there will be cost implications in implementing these evidence-based programmes.	Thank you for your comment. The GC considered evidence on cost-effectiveness and economic modelling, as well as the potential resource impact of potential interventions. Where cost-effectiveness evidence or economic modelling was not available, the committee made 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence. 'Consider' means that practitioners should think about providing the intervention, rather than that they must

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					offer it. The committee also took in to account the availability of therapeutic interventions. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Given all these considerations, the recommendations were felt by the GC to be aspirational but achievable.
Royal College of Paediatrics and Child Health	Short	21	7	Question 2: 'Practical support to attend appointments' – again, which organisation will provide the resources to make this happen?	Thank you for your comment. Support to attend appointments is only one example given to illustrate what was meant by 'practical support'. This was derived from evidence that parents value a wide range of help. The GC discussed the issue of resourcing and agreed to include explicit reference to the need to signpost families to sources of advice, resource and advocacy (1.5.5).
Royal College of Paediatrics and Child Health	short	22	19-21	Question 1: It may be challenging for mental health services in some areas to provide adequate support to children, especially 'early emotional support'.	Thank you for your comment. The GC considered the likely resource impact of potential interventions, alongside evidence from economic modelling, and agreed that those featured in the final guideline are aspirational but achievable.
Royal College of Paediatrics and Child Health	Short	22	26	A short statement about how toxic domestic violence is for mother and child would not go amiss. It is in the evidence section.	Thank you for your comment. The GC agreed that domestic violence has a significant impact on all members of a family. This is discussed in detail in the NICE guideline on Domestic Violence which is cross-referenced in this guideline.
Royal College of Paediatrics and Child Health	Short	23	8	This section on therapeutic intervention is most welcome and recommends specific therapeutic modalities that have a sound evidence base. Questions 1 and 2: However, they might well be a challenge to implement and have cost implications as they are not widely available, will require training in many instances, and the appointment of psychotherapists and trained social workers who can deliver these therapies. There might be pressure on CAMHS waiting times and these are already too long, and 'offering a choice of proposed interventions…delivered in the home' will prove impossible for already stretched mental health services. Despite this, these recommendations should stand as an acknowledgement of where we should be in therapeutic intervention for vulnerable and traumatised children and young people with emotional dysregulation and attachment difficulties. Opportunities for properly conducted RCTs should always be considered but these would need to be multicentre.	Thank you for your comment and support for the recommendations on therapeutic interventions. The guideline committee were mindful of the potential resource impact of the recommendations in relation to therapeutic interventions, including existing availability of the interventions. As part of developing the recommendations, the committee took in to account cost-effectiveness evidence and economic modelling data where available, aiming to ensure that implementing the recommendations would represent good value for money. Where cost-effectiveness evidence or economic modelling was not available, the committee made 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence, as a means of promoting good practice. 'Consider' means that practitioners should think about providing the intervention, rather than that they must offer it. The committee also took in to account the availability of therapeutic interventions. Whilst it was acknowledged

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					that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Given all these considerations, the recommendations were felt by the GC to be aspirational but achievable. There are a number of research recommendations specifying well-designed studies on intervention effectiveness (e.g. 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 2.13, 2.14, 2.15, 2.16)
Royal College of Paediatrics and Child Health	Short	24	10, 11 and 22	The above applies to individual psychotherapy (the Cicchetti Toth model of parent child psychotherapy).	Thank you for your comment and support for the recommendations on therapeutic interventions. The guideline committee were mindful of the potential resource impact of the recommendations in relation to therapeutic interventions, including existing availability of the interventions. With regard to child-parent psychotherapy specifically, these recommendations were adapted from NICE's guideline on children's attachment. The guideline committee considered the availability of this intervention. Whilst it was acknowledged that there would be regional variation in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision.
Royal College of Paediatrics and Child Health	Short	25	11	The above applies to parent-child interaction therapy.	Thank you for your comment and support for the recommendations on therapeutic interventions. The guideline committee were mindful of the potential resource impact of the recommendations in relation to therapeutic interventions, including existing availability of the interventions. As part of developing the recommendations, the committee took in to account cost-effectiveness evidence and economic modelling data where available, aiming to ensure that implementing the recommendations would represent good value for money. With regard to parent-child interaction therapy specifically no cost-effectiveness evidence was identified. However, the committee thought it was important to make a recommendation based on the effectiveness evidence, to highlight good practice as identified in the evidence base. The guideline committee considered the availability of this intervention. Whilst it

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					was acknowledged that there would be regional variation in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. This is a 'consider' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it.
Royal College of Paediatrics and Child Health	Short	25	17	The above applies to MST, although this is far more widely available in the NHS and third sector.	Thank you for your comment and support for the recommendations on therapeutic interventions. The guideline committee were mindful of the potential resource impact of the recommendations in relation to therapeutic interventions, including existing availability of the interventions. As part of developing the recommendations, the committee took in to account cost-effectiveness evidence and economic modelling data where available, aiming to ensure that implementing the recommendations would represent good value for money. With regard to multi-systemic therapy specifically no cost-effectiveness evidence was identified. However, the committee thought it was important to make a recommendation based on the effectiveness evidence, to highlight good practice as identified in the evidence base. The guideline committee considered the availability of this intervention. Whilst it was acknowledged that there would be regional variation in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. This is a 'consider' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it.
Royal College of Paediatrics and Child Health	short	25	23	Questions 1 and 2: It may be challenging for social work services to provide a round-the-clock support service to families to help them manage crises. Resources are limited, and there would be a cost associated with this. In some smaller areas, there may not be enough episodes where families call for support out of hours for it to be cost effective to provide a 24-hour service.	Thank you for your comment. The committee decided to make a 'consider' rather than an 'offer' recommendation, meaning practitioners should think about providing the intervention, rather than that they must offer it. The guideline committee carefully the resource impact of this recommendation, including searching for cost-effectiveness evidence, but none was available. The committee thought it was important to make this recommendation

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					based on the evidence of effectiveness of MST-CAN, of which the on-call service was a component. The view of the committee was that the on-call service does not necessarily need to comprise trained professionals, but rather to act as a 'helpline' function – which could potentially have less resource impact.
Royal College of Paediatrics and Child Health	Short	26	28	The above (comment re page 23 line 8) applies to trauma-based CBT, although it has been commissioned in some areas.	Thank you for your comment. The guideline committee considered carefully the resource impact of this recommendation. Economic modelling suggested that the intervention could be cost-effective. In terms of resource impact, the view of the committee was that this is a relatively widely available intervention.
Royal College of Paediatrics and Child Health	Short	27	8-10	The above (comment re page 23 line 8) applies to "Letting the Future In".	Thank you for your comment and support for the recommendations on therapeutic interventions. The guideline committee were mindful of the potential resource impact of the recommendations in relation to therapeutic interventions, including existing availability of the interventions. As part of developing the recommendations, the committee took in to account cost-effectiveness evidence and economic modelling data where available, aiming to ensure that implementing the recommendations would represent good value for money. No cost-effectiveness evidence was available for this intervention. However, the committee thought it was important to make a recommendation based on the effectiveness evidence, to highlight good practice as identified in the evidence base. The committee considered the availability of this intervention. They acknowledged that there was likely to be variation in the availability of this type of intervention, but that in their experience similar interventions were available, often within the voluntary sector. The committee thought it was important to make a recommendation to highlight good practice, and also to provide alternatives to trauma-focused CBT, given the evidence that not all children and young people find this approach acceptable. The view of the committee was that it was appropriate to make a 'consider' recommendation, meaning that practitioners should think about providing the intervention, rather than that they must offer it.
Royal College of Paediatrics and Child Health	Short	27	28	Agree that planning *continuity of services* is vital and this has been sadly lacking. Questions 1 and 2: This will be a real challenge for two reasons: it will need a dramatic change in mind-set and culture to overcome decades of short-termism in working with children and families and these services will need to be effectively commissioned.	Thank you for your comment. The guideline committee also recognised that this may be challenging to implement, but acknowledged the strength of evidence from children, young people and families that they would value greater continuity.
Royal College of Paediatrics	Short	28	22 – 24	Information sharing via agreed databases would be the way forward and does not require co-location of services. In the	Thank you for your comment. The

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and Child Health				city of Edinburgh, all strategy discussions are entered into an electronic database which is shared between the key agencies and accessible to professionals within Health, Social Services and Police.	recommendation referring to co-location has been removed following consultation feedback. We will pass this practice example to our implementation colleagues.
Royal College of Paediatrics and Child Health	short	29	13	Question 1: Providing emotional support for staff is challenging. Not all staff feel they need support, and it would be a drain on resources for little benefit to provide support for all staff. Staff needing support should know how to seek it within their own agencies, but this may have to be in the form of mentoring, supervision or peer review rather than access to a psychologist in all but the most severe of cases.	Thank you for your comment. The GC felt strongly that this should be included in the package of overall support provided to practitioners. The wording of this recommendation allows flexibility to implement this according to the particular practitioner's needs and circumstances.
Royal College of Paediatrics and Child Health	Short	29	14	CPD must also involve peer review.	Thank you for your comment. Recommendations 1.3.9-1.3.11 have been updated to make reference to existing guidance and protocols on supporting practitioners to recognise abuse and neglect. CPD is referenced in recommendation 1.8.5 to emphasise its importance in a package of support for staff. The GC did not have effectiveness evidence that would enable them to specify the specific components of a CPD for the wide range of practitioners covered by this guideline.
Royal College of Paediatrics and Child Health	Short	30	6	Bullying should include more on cyberbullying. Although the term is referred to on P31 line 7, under Emotional abuse, cyberbullying is now so widespread that it merits a separate section and definition by itself. Combining it under Emotional Abuse diminishes its impact and is an incorrect label.	Thank you for your comment. We have added a research recommendation on online facilitated abuse, to reflect consultation feedback on this theme.
Royal College of Psychiatrists	Short Version			**1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.** - Resources available for home visiting parenting programmes. - Resources and skills for attachment based interventions within CAMHS – evidence base, funding. - Training required re trauma focused CBT. - Impact on capacity- without additional resources – increased impact on current waiting lists.	Thank you for your comments. These will be helpful for NICE as they work to implement the guideline. The introduction has also been updated to demonstrate the value of this guidance to those responsible for commissioning, planning and delivering support. With regard to available resources, the guideline committee has taken in to account resource impact and cost effectiveness in developing the recommendations. Trauma-focused CBT (recommendation 1.7.17) is supported by economic modelling evidence. The recommendations on attachment-based interventions (recommendations 1.7.4, 1.7.5, 1.7.8 and 1.7.9) are adapted from the NICE guideline on children's attachment. For home visiting, there was no economic evidence. However, the guideline committee considered the potential costs of not intervening in families showing possible early signs of abuse and neglect, in terms of the potential for problems to become more serious and to result in greater service use and other costs in the future.
Royal College of Psychiatrists	Short Version			**2. Would implementation of any of the draft recommendations have significant cost implications?** - Cost implications of above. - Having staff trained specifically in safeguarding supervision. - Impact on resources and clinical capacity.	Thank you for your comments. As noted above, the GC considered carefully the likely resource impact of the recommendations, using cost-effectiveness evidence and economic modelling where available, and agreed that those in the final draft are aspirational but achievable.

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Royal College of Psychiatrists	Short Version			1. What would help users overcome any challenges? Integrating CAMHS/Children's services teams for LAC; children on CPP etc. Other comments – be helpful to have update on evidence based interventions on insecure/disorganised attachments	Thank you for your comment. We will pass your feedback regarding implementation to our implementation colleagues. For information, there is a separate NICE guideline on attachment which contains evidence based recommendations on identifying and treating attachment disorders.
Royal College of Psychiatrists	Full version	264	Section 5	Awareness of Risk: Resources to have intensive and consistent inter-professional discourse, in relation to SCRs- especially in view on gaps in workforce staffing and high staff turnovers in specialist CAMHS and in GP services.	Thank you for your comment. The GC agreed multi-professional discourse and learning is important within an overall multi-agency framework for support. After discussion post-consultation, they agreed it is important not to replicate what is already in Working Together 2015 and, to this end, have sought to simplify the guideline so it builds on rather than replicates existing guidance. This has been more clearly articulated throughout the guideline.
Royal College of Psychiatrists	Full version	265	Section 6	Care-experienced young people's views of support to address risk of child sexual exploitation: Resources to have intensive and consistent discourse to hear "Voice of the Child"- especially in view on gaps in workforce staffing and high staff turnovers in specialist CAMHS, Social Services and in GP services.	Thank you for your comment. There is a research recommendation focused on identifying effective approaches to enable children at risk of, of subject to sexual abuse to tell earlier (2.1).
Royal College of Psychiatrists	Full Version	General	General	A general comment, that any guideline is likely to be more useful if it pays proper attention to the whole system. There are challenges to efficacy of well-intended child protection policy from inconsistencies of practice & limited understanding between agencies of what each may offer. This can lead to delay & potentially costly repetition. A possible solution might be to promote more joined up, cross agency learning especially in the areas of preventative strategy & proposed `therapeutic` working in its widest sense. There are however cost and resource allocation implications for such a set-up.	Thank you for your comment. The GC revised the guideline structure and content post-consultation, with the aim of making clearer how the recommendations fit within the overall system of support. . The GC agreed multi-agency learning could be useful After discussion post-consultation, they agreed it is important not to replicate what is already in Working Together 2015 and, to this end, have made reference to this throughout the guideline.
Royal College of Psychiatrists	Full Version	General	General	A general comment, to strongly emphasize the importance of user/patient involvement in refining these guidelines with a feeling that professionals (including experts) lose much value by failing to incorporate experiential learning from people who have survived the gauntlet of professional systems in the Child Protection sector, including the prosecution services & the courts.	Thank you for your comment. Service users, including children and young people, have been involved in developing and refining the guidelines. For more information see pages 55 and 56 of the full guideline.
Royal College of Psychiatrists	Full Version	General	General	A general comment on the theme of joining up of knowledge & practice. For example, the NICE Guidelines to be guided and made aware of fundamental sources of advice contained in, for example, the College`s Values Based Commissioning Document pioneered by Peter Hindley & Baroness Tyler which distils much generalisable wisdom on the construction of services which aim to safeguard & improve mental health & wellbeing in children & young people.	Thank you for your comment. The guideline committee revised the guideline structure and content post-consultation, with the aim of making clearer how the recommendations fit within the overall system of support. NICE guidelines are based on review of the best available empirical evidence. Our review protocol did not therefore include review of other guidance documents.
Royal College of Psychiatrists	Full Version	General	General	A general comment that children, families, professionals and experts live in the real world. Therefore, we should not miss the opportunity to highlight important factors underlying the substrate of child abuse & neglect i.e. poverty, disenfranchisement, the occasions of negative aspects of media coverage of issues relating to neglect & abuse as well as the increasingly bellicose & defensive positions of political leaders. There should be consideration for the cumulative impact of such a complex matrix and consequences that could have for the vulnerable children and young people.	Thank you for your comment. We have added in reference to environmental factors such as poverty in recommendation 1.3.2.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	5	1	Cost of maintaining interpreter services for everyone when required	Thank you for your comment. The committee carefully considered the resource impact of this, but noted that this is important from an equalities point of

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					view.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	19	21	Understanding which professional group would be responsible for this , who co-ordinates this? Defined as specific time scales - considering who best placed to provide this. This is a targeted offer – would need to ensure that the delivery of this is not expected from the Universal services.	Thank you for your comment. We have amended the wording of recommendations 1.5.13 and 1.5.16 to make clearer that this intervention is seen as being additional to universal health visiting service provided through the Healthy Child programme, and should be delivered by professionals who have been specifically trained in that intervention.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	20	13-24	currently no staff trained in either of the recommended training programmes	Thank you for your comment. NICE guidelines describe the most appropriate interventions based on the best available evidence about what works. We have updated the introduction to make clear that, by doing this, it offers commissioners (as well as practitioners) a clear guide to the interventions and approaches that are most appropriate, and represent best value for money, under different circumstances. The GC considered carefully the potential resource impact of recommendations alongside effectiveness evidence and agreed the recommendations were aspirational but achievable.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	21	4	This role would fit within Early Help	Thank you for your comment which is likely to be useful in respect of NICE's work on implementation support.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	22	21	Early emotional support – ensuring this available for all these children will require consistent availability of this provision	Thank you for your comment which is likely to be useful in respect of NICE's work on implementation support.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	23	25	What intervention? That is evidence based	Thank you for your comment. We have added reference to an example of an effective intervention (Attachment and Biobehavioural Catch Up) to this recommendation (now 1.7.4).
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	24	7-20	This may have cost implications to ensure that available to all families in this group	Thank you for your comment. We have added a diagram in this section to make clearer which interventions are most suitable for different groups of families and children. The GC considered carefully the potential resource impact of interventions and agreed that the final recommendations are aspirational but achievable.
[Rotherham,Doncaster and South Humber trust Childrens Care Group	short	24	22	Cost implications	Thank you for your comment. We have added a diagram in this section to make clearer which interventions are most suitable for different groups of families and children. The GC considered carefully the potential resource impact of interventions and agreed that the final recommendations are aspirational but achievable.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	25	1-24	Cost implications	Thank you for your comment. We have added a diagram in this section to make clearer which interventions are most suitable for different groups of families and children. The GC considered carefully the potential resource impact of interventions and agreed that the final recommendations are aspirational but achievable.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	25	25	Ensuring that this is available in a consistent manner and possible cost implications	Thank you for your comment. We have added a diagram in this section to make clearer which interventions are most suitable for different groups of families and children. The GC considered carefully the

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					potential resource impact of interventions and agreed that the final recommendations are aspirational but achievable.
Rotherham, oncaster and South Humber trust Childrens Care Group	short	26	26	? CAMHS services best placed to provide this – cost implications	Thank you for your comment which is likely to be helpful for ongoing implementation work.. The GC considered carefully the potential resource impact of interventions and agreed that the final recommendations are aspirational but achievable.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	27	8	Letting the future in – training implications and cost	Thank you for your comment. Letting the Future In is cited as an example of an effective intervention for this group of young people. The GC agreed to list the specific intervention components, to allow some flexibility at the local level. The GC considered carefully the potential resource impact of interventions and agreed that the final recommendations are aspirational but achievable.
Rotherham, Doncaster and South Humber trust Childrens Care Group	short	29	24	Buildings capacity are a difficulty for staff to co-locate	Thank you for your comment. In response to your, and others', feedback we have removed reference to co-location as a stand-alone recommendation, but included it within the recommendation relating to information sharing. This aims to highlight that co-location is one means to support information sharing but there are others.
Revolution Consulting Limited	Full and Short	General	General	Children's Homes look after the most vulnerable cohorts of abused and neglected children in the country. The documents hardly mention this role or its impact. Without a full and evidenced analysis of the role of all social care services in this guidance we risk failing those who have suffered the most. Children in the care system more generally do not have strong advocates; they can become hidden from public view. We must seek out their experiences and target our most comprehensive efforts to improving their lot. Provider organisations have a wealth of information that could be accessed to better inform these guidelines. I suggest contacting ICHA and NASS and NAFP to access these sources.	Thank you for your comment. There is a separate NICE guideline on looked after children which includes a number of recommendations relating to children's homes. We have added in references to signpost people to this guideline at the relevant points.
Revolution Consulting Limited	Full and Short	General	General	Commissioning of £billions of special school, fostering and residential services is done with almost no evidence base as to what needs are being addressed, how they are being addressed, and the impact of the approaches and settings on outcomes. Your guidance must look to address the lack of rigorous needs profiling, the lack of comprehensive research into the impact of different settings and interventions and therapeutic approaches on different needs profiles. I repeat that to fail to do this in the context of our most vulnerable looked after children looks like the biggest failing of this guidance. But the research must also look at how failing local authority commissioning, procurement and referral and placement activity is itself further abuse and neglect. A child who came into the care system through abuse and neglect by parents or family and who is then inappropriately placed in a serial fashion (extreme, but real, cases highlight children in the care system in their teens who have experienced 30, 40 or more broken placements in care) is in my view being subjected to further abuse by its corporate parent. If your guidance fails to begin to tackle this then it will fail our most needy, most abused, and your guidance itself will have neglected a cohort who most need NICE to tackle this abuse. I apologise that I have only encountered this very late in your consultation and may have overlooked important areas where you may have started work in these areas. My comments are based on word and phrase searches.	Thank you for your comment. As noted above, there is a separate NICE guideline on looked after children. We have added in references to signpost people to this guideline at the relevant points.

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SafeLives	Short	7	13	It would be good to include a section here about the links between Domestic Abuse and Child abuse and neglect. For example, statistics show from SafeLives' research that there is a major overlap between direct harm to children and domestic abuse: 62% of children exposed to domestic abuse in our research were also directly harmed. http://www.safelives.org.uk/sites/default/files /resources/Final%20policy%20report%20In% 20plain%20sight%20-%20effective%20help% 20for%20children%20exposed%20to%20domestic %20abuse.pdf Research studies show a clear link between domestic abuse and child maltreatment and domestic abuse has been shown to be a factor in two thirds of Serious Case Reviews. Practitioners need to be familiar with the warning signs of domestic abuse and they should feel confident in using the DASH to assess the level of risk.	Thank you for your comment, and for drawing the SafeLives report to our attention. This report was included in our initial searches, and considered for inclusion in RQ3. However, in order to broaden the data sources as much as possible, a decision was made to only use systematic reviews for this research question, so that the SafeLives report was not eligible for inclusion. Domestic abuse is discussed in detail in the NICE guideline on Domestic Violence which is cross-referenced in this guideline.
SafeLives	Short	9	7, 12	Highlight the impact of domestic abuse on the adult victim's ability to provide effective parenting. The abuser will often attempt to disrupt parenting as a method of control. include current domestic abuse in this list Under this section it would be helpful to provide a list of the risk factors associated with domestic abuse from the adult victim perspective. Eg. an adult victim of domestic abuse may present with unexplained bruising and physical injuries, they may not be able to attend appointments of their own if their partner insists on attending with them, they may be isolated from friends and family, may be anxious during appointments. You may observe the partner being verbally abusive or controlling. Use of DASH if DA is disclosed. Practitioners should be familiar with the DASH.	Thank you for your comment. The GC agreed that domestic violence has a significant impact on all members of a family. This is discussed in detail in the NICE guideline on Domestic Violence which is cross-referenced in this guideline.
SafeLives	Short	10	6 - Box 1 bullet on coercive and controlling behaviour	Highlight that this sort of behaviour can present following domestic abuse when the adult victim has separated from the abuser.	Thank you for your comment. The GC agreed that domestic violence has a significant impact on all members of a family. The NICE guideline on Domestic Violence is cross-referenced in this guideline.
SafeLives	Short	11	General	An additional clause: Consider current or past abuse and neglect if you are aware or suspect domestic abuse including violence, emotional abuse, stalking and harassment and coercive control.	Thank you for your comment. The GC agreed that domestic violence has a significant impact on all members of a family. The NICE guideline on Domestic Violence is cross-referenced in this guideline.
SafeLives	Short	14	12,20	Consider emotional abuse if the child is living in a household where domestic abuse occurs. (the bit about parent-carer interactions is a bit misleading as it indicates that children are only harmed if they are directly involved in DA but we know that they are harmed by indirect involvement including being upstairs in bed and hearing the abuse) Feels like this also needs some explanation that the abuser is responsible for the harm and not the adult victim of DA Consider post separation abuse – child contact often used to continue to exert control.	Thank you for your comment. The GC agreed that domestic violence has a significant impact on all members of a family. The NICE guideline on Domestic Violence is cross-referenced in this guideline.
SafeLives	Short	16	10	Include training in domestic abuse and knowledge of local DA provision and referral pathways	Thank you for your comment. The GC agreed that domestic violence has a

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					significant impact on all members of a family. The NICE guideline on Domestic Violence is cross-referenced in this guideline.
SafeLives	Short	17	20	Where domestic abuse is suspected ensure that practitioners consider the safety of the adult victim. Informing the abuser of a disclosure would increase the risk to the adult victim and must be avoided.	Thank you for your comment. We have amended the wording of this recommendation to make it clear that information should be gathered only when it is safe to do so.
SafeLives	short	19	1, 25, 27	'to avoid placing the child, or an adult victim in the case of domestic abuse, as risk… 6 months feels very prescriptive. Would be better for this to be led by the needs of the adult victim and child Home visits – not always safe for parents experiencing domestic abuse. Programme of support doesn't need to happen in the home	Thank you for your comment. We have amended the wording of recommendation 1.4.5 to include reference to adult victims of domestic abuse. In relation to home visiting, this intervention would not be intended for families where there is current domestic abuse. We have amended the wording to make clearer that the intervention should address problems arising from previous domestic abuse, but discovery of domestic abuse would necessitate referral to chidlren's social care. The recommended duration of 6 months is based on the research evidence.
SafeLives	short	20	6 & 7 13 20 12 onwards	Include domestic abuse in this list Parenting programme – only appropriate in DA cases where the adult victim is now safe . Need to be specific for parents who have experienced DA as this will have impacted on their parenting and needs to be acknowledged. anger management – just a note to say that this isn't appropriate in cases of DA. DA is about control not anger and studies have shown that anger management courses can increase risk to DA victim. This whole section requires a caveat about DA. The adult victim/parent needs to be safe before any work to support their parenting can begin. Any work with the abuser needs to be done separately from work with the child and adult victim in cases of DA. Not family work.	Thank you for your comment. These recommendations relate to interventions for families at risk of abuse or neglect, not those in which abuse is already occurring. In line with the Adoption and Children Act 2002 we would regard exposure to domestic abuse as abuse. Therefore these recommendations would not be suitable for families in which domestic abuse was occurring.
SafeLives	Short	22	4 27	where DA is suspected consider how these meetings can be conducted safely to ensure the adult victim can contribute honestly and in confidence. Ensure that all professionals who work with families are aware of the indicators of DA and have the confidence and skills to communicate with children ……..on how to use the DASH and make a referral. *Not just police who will identify DA, many families do not have any contact with police, all professionals should be alert to DA and act appropriately.* Include a sentence about how about young people can experience DA in their own relationships – professionals should be alert to this. Young persons' DASH: http://www.safelives.org.uk/sites/default/files/resources /YP%20RIC%20guidance%20FINAL.pdf	Thank you for your comment. The GC agreed that domestic violence has a significant impact on all members of a family. We have amended the wording of recommendation 1.4.5 to include reference to adult victims of domestic abuse. **The NICE guideline on Domestic Violence is cross-referenced in this guideline.** Thank you for suggesting that the SafeLives 2014 report 'Risk Identification Checklist for the identification of high risk cases of domestic abuse, stalking and 'honour'-based violence Young People's Version with practice guidance' be considered for inclusion in the Guideline. The report was originally ruled out, as it was not based on original research, but is now being considered for additional post-consultation screening.
SafeLives	Short	23	8 onwards	All seems quite unrealistic given pressures on services. Great to recommend but not sure professionals will be able to access these services for families they are working with?	Thank you for your comment. The GC considered carefully the likely resource impact of the guideline and the final set of

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				Really need to be careful in cases of DA to ensure that the children are now safe, for example, children may still have contact with the abusing parent.	recommendations were considered to be aspirational but achievable.
SafeLives	Short	25	23	very unrealistic – we know of no areas which provide this service for families with DA.	Thank you for your comment. The guideline committee carefully the resource impact of this recommendation. This is a 'consider' rather than an 'offer' recommendation, meaning practitioners should think about providing the intervention, rather than that they must offer it. However, the committee thought it was important to make this recommendation based on the evidence of effectiveness of MST-CAN, of which the on-call service was a component. The view of the committee was that the on-call service does not necessarily need to comprise trained professionals, but rather to act as a 'helpline' function.
SafeLives	short	29	16	need to include domestic abuse including some recognition that young people can experience DA in their own intimate relationships and they can be the one causing the harm. This does not mean that they do not have safeguarding risks of their own and these should not be overlooked.	Thank you for your comment.The NICE guideline on Domestic Violence is cross-referenced in this guideline.
SafeLives	Short	General	general	It would be really good to see a paragraph or section that provides some guidance for practitioners for how they should respond to alleged or suspected perpetrators of domestic abuse. Something that alerts them to the tactics often used to control professionals and the need to remain vigilant to this. The recommendations for research don't include anything which covers DA which is disappointing. The new DH Guidance includes a number of research studies which could be helpful: https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals It would be good to see a recommendation that services identify a Lead professional who can offer specialist DA support to colleagues, for example in the IRIS model, an Advocate Educator: http://www.irisdomesticviolence.org.uk/iris/	Thank you for your comment.The NICE guideline on Domestic Violence is cross-referenced in this guideline. This also includes recommenations for DA-specific research.
Special Needs Jungle LTD	Short	8	25	We found this statement to be misleading in the context that it is given and therefore may lead to confusion in interpreting how to apply it. The child being disabled is the only given increased risk factor for a parent abusing their child. This statement implies that parenting a disabled child is to be considered as grounds for suspicion. We believe that this sends wholly the wrong message to practitioners working with disabled children and their families who usually have to interact with services far more frequently than other families.	Thank you for your comment. Recommendation 1.2.7 has been reworded to make clear that being disabled is a vulnerability factor for the child – reference to carers has been removed. We have added text to the introduction of this section highlighting that these factors are not deterministic of abuse and neglect and practitioners should use professional judgement where these vulnerability factors are present.
Special Needs Jungle LTD	short	9	14	Families of disabled children often find themselves involved with multiple services and to have had to fight for some or all of their child's access to these services. It is not uncommon for parents of complex children to find themselves in an adversarial position as a result, especially as many of the services have had their budgets cut and therefore are unable to meet the needs of all the children who require their services. Parents of disabled children are also 'experts by experience', and have a far clearer understanding of how their child's condition affects them, than the practitioners who see them for a few minutes every 6 months. This can sometimes place the parents in the position of having to challenge a decision made by a practitioner involved with their child who cannot possibly know that child as holistically and intricately as the parents. Our concern is therefore that this statement is easily misinterpreted, and will become a barrier to parents who feel that it is necessary to challenge or disagree with the services with which their child is involved. At Special Needs Jungle we are aware of a steadily increase in the numbers of parents finding themselves referred on child protection grounds as a result of having disagreed with or tried to engage with over-stretched services. It is our concern that statements such as this which are not clarified, will be misleading for practitioners and parents of disabled children will find their ability to work with services compromised as a result. We would also question whether or not the process of assessing parents against risk factors in itself causes a breakdown in the relationship between practitioners and families as it questions the validity of information provided by	Thank you for your comment. The guideline committee recognised the valuable insights parents and carers can provide and, to this end, developed two over-arching recommendations focused on involving them sensitively and appropriately (1.1.10 and 1.1.11).

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				the parents.	
Special Needs Jungle LTD	Short	9	17	It is well known that parents of disabled children are far more likely to be living with a level of stress well beyond that experienced by other parents. I is reasonable to assume that if a parent believed a practitioner was considering making a child protection referral, then any parent would experience extremely high levels of stress, worry and anxiety around the implications that such a process might have. We would therefore question whether this statement is self-fulfilling, insofar as the process of exploring whether there are any risk factors evident, is likely to cause the very signs that the practitioners are told to look for.	Thank you for your comment. The guideline committee were mindful of the stress that child protection procedures can place on parents and carers. Recommendations 1.2.3 and 1.2.4 aim to highlight vulnerability factors for abuse and neglect. We have added text to the introduction of this section highlighting that pracittioners should use professional judgement where these vulnerability factors are present.
Special Needs Jungle LTD	Short	9	26	This section of the guidance has caused us considerable concern as we believe that it directly discriminates against disabled children and has the potential to cause substantial harm to disabled children and their families. We would like to highlight the fact that disability, in itself, will cause disabled children to differ from what would be expected for their age and developmental stage. This means that this statement is very misleading and could lead to confusion over which children should be referred. As presently written, we believe there is a serious risk that practically all parents of children with developmental delays might fall under suspicion of abuse and neglect. Additionally, we would question the legality of such a statement without context or caveat. In addition to this, the document fails to stress the behavioural aspects of many disabilities that may closely mimic the listed indicators of abuse and the importance of consulting with an expert on the child's specific disability and its presentation before acting on the guidelines. As it stands, the guidance would be difficult for anyone to implement without specific expertise in various disabilities that may also present in the same way. We are deeply concerned that without this matter being adequately addressed, it would be both confusing and inaccurate for practitioners working with disabled children. We also believe that as it stands it also poses a risk that disabled children and their families may be fearful of accessing the support that they need in a timely manner, due to child protection concerns being raised where they are unwarranted. It is our view that this lack of clarity and the conflict with existing evidence about behaviours seen in disabled children, means that there is a risk of disabled children and their families being caused harm by the implementation of the guidelines.	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders.
Special Needs Jungle LTD	Short	10	6	We believe that the examples given are misleading. They do not consider the large weight of scientific evidence showing that such behaviours are caused by developmental disorders as opposed to child abuse. Therefore, this list gives unwarranted weight to the claim that such behaviours are caused by abuse. This is particularly true where there is little, if any, evidence to support that this is more than subjective opinion. As a result, we believe that the inclusion of these indicators as 'fact', without reference to statistical probabilities that these behaviours are far more likely to be caused by developmental disorders, could potentially cause harm to families with a disabled child. For example, most parents of a child on the autistic spectrum would recognise many of the behavioural and emotional indicators as being behaviour that they see every day. This is corroborated by the International Classification of Diseases, tenth edition (ICD-10) which identifies a number of profiles under the Pervasive Developmental Disorders heading into which these indicators would fit, as they do under the DSM-5 definition. But it is not only children on the autistic spectrum that display many of the behaviours and emotional responses listed. Many children with sensory issues, learning disabilities, mental health problems and bladder or bowel issues would also display some or many of the indicators. Special Needs Jungle would urge extreme caution on including guidance that encourages practitioners to act on indicators that are also well-documented as behaviours seen in many disabilities. These disabilities include rare conditions and those diseases that have not yet been clinically identified. We would question whether such an inclusion, without clear explanation, is discriminatory. Undoubtedly, as it stands, it likely to cause a great deal of anger and anxiety within the disabled community. We would also ask whether the guidance development process has considered that the very inclusion of these indicators could lead to situations that result in trauma to children and families. The harm that wrongful accusation causes families is well documented and there is substantial anecdotal evidence available amongst support groups.	Thank you for your comment. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders. The evidence on which these recommendations are based is drawn from systematic reviews and meta-analyses comparing the prevalence of particular risk factors and emotional, social and behavioural indicators in the abused versus non-abused population. A number of recommendations have also been adopted from the NICE guideline on child maltreatment, which is based on similar population data, as well as expert evidence from a survey of clinicians.

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				Special Needs Jungle has spoken to many families whose child has been refused access to services, including medical care, as a result of an unsubstantiated child protection referral, or more commonly, as the result of a child's condition having been 'risk assessed' as being possibly caused by abuse. Given the volume of disabled children who would potentially fall into this category if this list is accepted as factually accurate, we believe that it is vital that the consequences to innocent families MUST be a consideration before the guidelines are published.	
Special Needs Jungle LTD	Short	General	General	Special Needs Jungle is highly conscious that parents of disabled children are already at greater risk of being victims of wrongful accusation. This is because the system currently endorses a framework whereby parents wanting services for a child 'in need' are mandatorily 'risk assessed' in order to access them. Research carried out by Devine (2017) shows that risk assessment as a means to detect child abuse is no more effective than rolling a dice and picking families at random. It is of great concern, therefore, that guidelines like these are still being produced without due regard to the harm they may cause families and without assessing the subsequent negative impact. Based on the findings of Devine's research, (Rethinking child protection strategy: Progress and next steps. Seen and Heard, (2017) 26 (4). pp. 30-49) guidance that encourages practitioners to focus on risk indicators does not provide a consistent or reliable method of abuse prediction or prevention. In fact, it clearly showed that lowering the thresholds of concern, particularly on the basis of apparent 'signs of abuse', resulted in a reduced percentage of detected child abuse proportional to the number of children referred. We would also question the **validity** of the 'evidence' used to justify the inclusion of the indicators of abuse as seen in this draft document. Trying to look for indicators of abuse by using Serious Case Review or child protection records is a subjective process and more akin to opinion rather than reliable evidence. The behaviours are, however, very clearly evidenced and documented as being associated with disabilities. In fact, we are very concerned that this strong Thank you for your comment. and clear evidence was given far less weight than the subjective list of risk indicators that only serve to validate the guidance's existence. It is vital that guidance is based on tested, reproducible and non-subjective evidence that has been appropriately validated. If not, we run the risk of releasing guidance that will not only fail to help abused children, but will further overwhelm our already over-stretched social services and cause considerable harm to innocent families.	Thank you for your comment. The guideline committee considered carefully the risk of misdiagnosis of abuse and neglect of disabled children. The evidence on which these recommendations are based is drawn from systematic reviews and meta-analyses comparing the prevalence of particular risk factors and emotional, social and behavioural indicators in the abused versus non-abused population. A number of recommendations have also been adopted from the NICE guideline on child maltreatment, which is based on similar population data, as well as expert evidence from a survey of clinicians.
Special Needs Jungle LTD	Full	General	General	The evidence gathered, including the testimonies from expert witnesses, is not representative of all the people these guidelines will impact upon. It fails to properly explore the likelihood that these guidelines will be applied in error and the unwarranted consequences of this to children and their families. **Special Needs Jungle has contact with thousands of families with disabled children and we are greatly concerned that these guidelines were developed without proper research, understanding or expert testimony concerning how certain disabilities or conditions may mimic those given as signs of abuse.** The evidence search also failed to properly explore the consequences and possible harm that could be caused by incorrectly accusing parents of abuse. The expert witnesses and committee members did not include any experience of childhood disability and its presentation and did not invite input from experts dealing with false allegations of abuse. We therefore question whether the evidence is representative of the impact and consequences these guidelines may have to disabled children and their families. We do not believe the process has fully explored the possibility of significant harm being caused to the child and family because of inaccurate or unsubstantiated accusations. We would therefore question whether this guidance is capable of producing the positive outcomes that it is designed for. We would ask that due consideration is given to the fact that: 1. Our current system already subjects families of disabled children to unnecessarily intrusive levels of assessment in order to access basic services; 2. The evidence that referring based on risk prediction does not help detect more incidences of abuse; and 3. that these guidelines will directly discriminate against parents of disabled children and see specific	Thank you for your comment. The guideline committee were mindful of the similarity between alerting features for abuse and neglect, and behaviours and indicators associated with disability and learning disability. We have added text at the beginning of this section on alerting features to make clear that many of the alerting features can be similar to behaviour arising from other causes. Recommendations 1.3.12 to 1.3.14 also make reference to whether behaviours can be explained by medical cause or neurodevelopmental disorders. The guideline committee were also aware of the potential to increase the burden on services, particularly children's social care. The introduction to the section on 'alerting features' now highlights the importance of discussing concerns with specialist safeguarding colleagues within your organisation before making a referral, and suggests early help assessment as an alternative action, if any action is required. The evidence on which these recommendations are based is drawn from systematic reviews and meta-analyses comparing the prevalence of particular risk factors and emotional, social and behavioural indicators in the abused

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				development disorders targeted. We believe that there is enough evidence to raise serious concerns as to whether these guidelines risk causing more children and families harm than they help. The NICE guidelines are encouraging practitioners to look for 'soft' signs of abuse, this in turn will increase the number of referrals to social services, who are already over-stretched. Given that proportionally, the majority of the referrals will be of innocent families, including those with disabled children, Special Needs Jungle believes that we should be questioning the legitimacy of further increasing the number of families subjected to screening; a process which is known to be stressful and in some cases harmful. There is a large body of literature highlighting harm caused by referral and assessment (Dale *et al,* 2005, Jones, 2001:1395; Luza and Ortiz, 1991:108; Wakefield and Underwager, 1994 in Krivacska and Money (eds.), 1994; Prosser, 1995:9; Kaufman 2004), yet none of it was considered when evidence gathering for this guidance. As Devine (2017) states when referring to the literature available: **"Reports of such serious trauma arising from false positive referrals should not be ignored."** Equally, adequate care has not been taken to ensure that the evidence used to produce the risk indicators is scientifically sound and that all evidence has been considered, including that which does not support or validate the guidance. It is concerning that the guidance, and hence the practitioners who will be following the guidance, lacks information that the listed abuse 'indicators' are far more likely to be behaviours associated with a wide range of documented disabilities and conditions. As such, they should be viewed with caution until clear evidence indicates otherwise, to ensure that no harm comes to the child or family as a result of someone following the guidelines.	versus non-abused population. A number of recommendations have also been adopted from the NICE guideline on child maltreatment, which is based on similar population data, as well as expert evidence from a survey of clinicians.
South Eastern Trust	Full	General	general	The legal references are English Law – we work under the Children (NI) Order though the way it is referred to in this guidance it would be the same as NI Otherwise I think overall it is very good document	Thank you for your comment, note about implementation in your area and support for the guideline.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	General		Page 4 of the full draft guideline refers to the original scope for the guideline. Paragraph 2 of the Guideline scope states that "The guideline will cover physical, emotional and sexual abuse, and neglect (which are collectively referred to as 'abuse and neglect' or 'maltreatment') as defined in the Department for Education's statutory guidance Working together to safeguard children". This document, "Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children March 2015", defines neglect as follows: **"**The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: • provide adequate food, clothing and shelter (including exclusion from home or abandonment); • protect a child from physical and emotional harm or danger; • ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs". Since neglect includes a parent failing to protect a child from emotional harm and being neglectful of, or unresponsive to, a child's basic emotional needs, we would recommend the following amendments are made to the full draft guideline	Thank you for your comment. Your detailed feedback is addressed below.

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				(suggestions in tracked changes):	
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	14	1.2.1	Second bullet point, add 'or neglectful' so that it reads: 'they may not always recognise their own experiences as abusive or neglectful' Third bullet point, add 'or the person or persons neglecting them' so that it reads: 'they may be being coerced by (or may be attached to) their abuser or the person or persons neglecting them' Fourth bullet point, add 'or neglect' after 'the abuse' so that it reads: 'they may fear the consequences of telling someone, for example that the abuse or neglect might get worse, their family will be split up or they will go into care'. We suggest these changes because the current drafting should explicitly mention 'neglect' and not exclusively focus on 'abuse'.	Thank you for your comment. Recommendation 1.3.1 has been amended as you have suggested.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	15	1.2.9	We believe the following two items should be added to the bullet point list: ▯ They engage in frequent, intense, and poorly resolved interparental conflicts ▯ They (the parents) are chronically emotionally withdrawn to the extent that the relationship is devoid of warmth and affection We suggest these changes because the current wording '*there is a history of domestic abuse*' and '*they are emotionally volatile or have problems managing their anger'* do not cover the evidence contained in the Early Intervention Foundation's review – 'What works to enhance inter-parental relationships and improve outcomes for children' – which states that '*Parents/couples who engage in frequent, intense, and poorly resolved interparental conflicts put children's mental health and long-term life chances at risk*.' '*Children of all ages can be affected by destructive inter-parental conflict, with effects evidenced across infancy, childhood, adolescence, and adulthood.'* Furthermore, the lead author of the EIF's review, Professor Gordon Harold, has elsewhere reviewed the evidence on this area and concluded: "*Parents who are embroiled in a relationship that may be described as non-acrimonious, but who are emotionally withdrawn from each other to such an extent that the relationship is devoid of any warmth or affection, may put children as much at risk for long-term emotional and behavioural problems as parents involved in a relationship marked by frequent, intense, poorly resolved, and overtly hostile conflicts*" (Harold, G., & Leve, L. (2012). The current wording of the draft guideline makes no reference to the harmful consequences of 'silent' or 'non-acrimonious' inter-parental conflict, and we feel that this omission is mistaken since it misses out an important aspect of children's experience vis-à-vis neglect, which is significantly harmful to children's development. The draft guideline (2.4) acknowledges that 'a significant proportion of abuse and neglect remains undetected'; recommending that inter-parental conflict be included as a risk factor for neglect will ensure that some of neglect which is currently undetected becomes detected in future.	Thank you for your comment. Thank you for drawing our attention to literature about the negative impact that there can be for children whose parents' relationship is non-acrimonious, but who are emotionally withdrawn from each other. The concern of the Guideline would be whether this could be an indicator of abuse or neglect, and we did not find research evidence which would support including this type of parental relationship as one of the indicators that children were at risk of or being abused and/or neglected. Thank you for drawing our attention to what Harold and Leve have written on the subject. The quote you have supplied is from the chapter 'Parents as Partners: how the parental relationship affects children's psychological development' which they contributed to the book 'How Couple Relationships Shape our World: Clinical Practice, Research, and Policy Perspectives'. As this is a narrative literature review in a book chapter, not a systematic review, it does not meet our inclusion criteria.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	18	1.2.24	Add the words 'in material terms', in brackets, so that the first sentence after the bullet points reads: Be aware that it may be difficult to distinguish between neglect (in material terms) and material poverty. We suggest this change because we feel it is important that the guideline in no way gives the impression that neglect is solely material; this change, we believe, would ensure that the guideline explicitly refers to the fact that neglect can be both material *and* emotional, as per the definition being used by the guideline ('Working together to safeguard children' – DfE).	Thank you for your comment. This recommendation has been adopted from the NICE guideline on child maltreatment, and is based on the evidence reviewed by that guideline committee. The wording has therefore not been amended.
The Relationships Alliance (Relate, Tavistock	Full	20	1.2.31	Fourth bullet point, add the words 'frequent, intense, and poorly resolved interparental conflicts, or non-acrimonious but chronic conflict in the context of a relationship that is devoice of warmth or affection' after 'domestic abuse' so that it reads: 'Exposure to frightening or traumatic experiences, including domestic abuse, frequent, intense, and poorly resolved interparental conflicts, or non-acrimonious but chronic conflict in the context of a relationship that is devoice of	Thank you for your comment. This recommendation (now 1.3.31) is adopted from the NICE guideline on child maltreatment, and is based on the

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Relationships, One Plus One and Marriage Care)				warmth or affection'. Rationale for suggestions this change: while we are glad that the draft guideline acknowledges the example of 'in marital disputes' regarding 'Using the child for the fulfilment of the adult's needs', we feel that by singling out 'domestic violence' as the example of 'frightening or traumatic experiences' fails to acknowledge the well-evidenced harm to children that exposure to overt and non-overt inter-parental conflict can lead to. We understand that by including 'domestic violence' as an example, the guideline is not purporting to provide an exhaustive list of frightening or traumatic experiences; however, the guidelines present a significant opportunity to raise awareness among practitioners carrying out assessments of the harmful impacts of overt and non-overt inter-parental conflict.	evidence reviewed by the guideline committee for that guideline.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	22	1.2.46	Insert the words 'inter-parental conflict' into the first bullet point so that it reads: 'training newly qualified doctors in risk factors for abuse and neglect, such as parental mental health problems, inter-parental conflict, alcohol and substance misuse (and providing top-up training sessions every 6 months)'. Insert a new bullet point into this list: □ training new qualified paediatricians, midwives and home visitors to be able to recognise signs of inter-parental conflict in the parents of children they assess Rationale for suggesting this change: again, we feel that it is important that 'inter-parental conflict' is included on the list of examples, as it is insufficiently recognised as a risk factor for neglect. We also believe that paediatricians, midwives, home visitors etc. are well-placed to recognise inter-parental conflict as a risk factor for neglect, but are not currently trained in this.	Thank you for your comment.. The detail of these bullet points reflect the evidence reviewed, which did not specifically include inter-parental conflict.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	26	1.4.6	Add the following bullet point to the list: □ improve their co-parenting relationship Rationale for suggesting this change: the current guideline wording fails to reflect established evidence that the quality of the parental relationship has a significant impact on children's wellbeing (e.g. Harold et al., 2016). The guideline should include this aspect and, following on from that, should recommend interventions recommended by the Early Intervention Foundation in its review (Harold et al., 2016), including the Parents as Partners programme which was given the highest ratings of all programmes assessed in this review. The current focus of the guideline suggests that the Guideline Development Group is not sufficiently aware of the evidence relating to couple relationship quality (and co-parents' relationship quality) and children's outcomes, and we recommend that the guideline is changed accordingly to reflect the strength of this evidence base.	Thank you for your comment. The detail of these bullets reflect the evidence reviewed. 'What works to enhance inter-parental relationships and improve outcomes for children' (Harold et al. 2016) does not meet our inclusion criteria, as the population criteria for included studies did not focus specifically on children and young people at risk of, or experiencing abuse and neglect and their families, but has a broader focus on children in situations of parental conflict – which on many occasions would not constitute abuse or neglect. For more information see the review protocols in Appendix A.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	26	1.4.7	We believe that this section should recommend Parents as Partners alongside other parenting programmes. We make this recommendation on the basis of evaluation of the programme carried out by the Early Intervention Foundation. Reviewing the evidence for Parents as Partners, as well as 'Schoolchildren and their Families' – the US programme upon which Parents as Partners is modelled), the Early Intervention Foundation found: "A total of 15 interventions were identified for this review. Two of the interventions received a Level 3 rating (Parents as Partners and Schoolchildren and their Families), indicating an effective intervention at improving couple/inter-parental outcomes (one of these interventions also received a Level 3 for child outcomes – see below). In both cases, the interventions were underpinned by randomised control trials, in which participants were randomly assigned to the treatment and control groups through the use of methods appropriate for the circumstances and target population, with an 'intent-to-treat' design being used, alongside pre/post standardised outcome measurement. Improvements were seen in a range of outcomes, including improvements in father's psychological and behavioural involvement in family life, reduced parenting stress, increased couple satisfaction, and reduced couple conflict. These outcomes were measured using standardised measures which had been validated independently of the study. For both interventions there was some evidence of long-term outcomes, with some of the effects being sustained for 12 months or more. Both of these RCTs came from the US. However, one of the interventions also had supporting evidence from a pre-post design from the UK which met the criteria for a Level 2 rating". We are making this recommendation on the basis therefore that a number of studies (including RCTs) have demonstrated that the Parents as Partners/Supporting Father Involvement programmes (the different names refer to	Thank you for your comment. The recommended interventions reflect the evidence reviewed by the GC. We have added a diagram in this section to make clearer which interventions are most suitable for different groups of families and children. The GC considered carefully the potential impacts of interventions on a wide range of outcomes.

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				the same programme) can lead to improvements in father's psychological and behavioural involvement in family life and reduced couple conflict, both of which are associated with a definition of neglect which encompasses parental failure to respond to a child's basic psychological needs.	
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	29	1.6.5	Add the following bullet point to the list: □ emphasise the importance of attachment processes and highlight the role of children's emotional insecurity in the context of inter-parental conflict Rationale for inclusion: The Early Intervention Foundation's review – What works to enhance inter-parental relationships and improve outcomes for children – states "Davies and Cummings (1994) offer a complementary perspective suggesting that a child's sense of 'emotional security' is threatened in the context of inter-parental conflict. Derived from attachment theory, these authors propose that the effects of destructive and badly managed conflict between parents are explained through disruptions to three conceptually related areas of children's emotional functioning and general feelings of security within a family context. First, feelings of emotional reactivity may be affected such that children feel angry, sad, or scared in the context of conflict. Second, their representations of family relationships may be affected such that conflict between parents affects children's expectations that conflict will occur elsewhere in the family system (e.g. the parent–child relationships). Third, children may feel motivated to regulate exposure to interparental emotion so that they directly intervene in, or actively withdraw from, the immediate vicinity of the conflict. The impact of conflict on children is explained by the extent to which one or more of these aspects of emotional security is adversely affected and how well children can manage to regulate overall emotional disruption" (Harold et al., 2016).	Thank you for your comment. The detail of these bullets reflect the evidence reviewed. Thank you for your comment, and for the literature which you have suggested should be considered for inclusion in the Guideline. As professional practice in the area of child abuse and neglect is being constantly reviewed and updated, it was decided to have a cut-off point of 2004 in the review protocols for including studies in the guideline. A date cut-off is used to limit the volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal framework for how social services and other agencies deal with issues relating to children. For this reason, we would not be able to consider the perspective offered in Davies & Cummings (1994) which you have suggested. 'What works to enhance inter-parental relationships and improve outcomes for children' (Harold et al. 2016) does not meet our inclusion criteria, does not meet our inclusion criteria, as the population criteria for included studies did not focus specifically on children and young people at risk of, or experiencing abuse and neglect and their families, but has a broader focus on children in situations of parental conflict – which on many occasions would not constitute abuse or neglect. For more information see the review protocols in Appendix A.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	30	1.6.8	Add 'inter-parental conflict' to the bullet point list. Rationale for inclusion: Inter-parental conflict is linked to neglect and therefore should be addressed by any intervention seeking to help parents who have neglected a child.	Thank you for your comment. The components of the intervention described in this recommendation (now 1.7.10) are based on the evidence reviewed.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	44	2.10	We would draw the GDG's attention to the Early Intervention Foundation's review – What works to enhance inter-parental relationships and improve outcomes for children – which found: "A total of 15 interventions were identified for this review. Two of the interventions received a Level 3 rating (Parents as Partners and Schoolchildren and their Families), indicating an effective intervention at improving couple/inter-parental outcomes (one of these interventions also received a Level 3 for child outcomes – see below). In both cases, the interventions were underpinned by randomised control trials, in which participants were randomly assigned to the treatment and control groups through the use of methods appropriate for the circumstances and target population, with an 'intent-to-treat' design being used, alongside pre/post standardised outcome measurement. Improvements were seen in a range of outcomes, including improvements in father's psychological and behavioural involvement in family life, reduced parenting stress, increased couple satisfaction, and reduced couple conflict. These outcomes were measured using standardised measures which had been validated independently of the study. For both interventions there was some evidence of long-term outcomes, with some of the effects being sustained for 12 months or more. Both of these RCTs came from the US. However, one of the interventions also had supporting evidence from a pre-post design from the UK which met the criteria for a Level 2 rating".	Thank you for your comment. The detail of these bullets reflect the evidence reviewed. 'What works to enhance inter-parental relationships and improve outcomes for children' (Harold et al. 2016) does not meet our inclusion criteria, does not meet our inclusion criteria, as the population criteria for included studies did not focus specifically on children and young people at risk of, or experiencing abuse and neglect and their families, but has a broader focus on children in situations of parental conflict – which on many occasions would not constitute

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				We are making this recommendation on the basis therefore that a number of studies (including RCTs) have demonstrated that the Parents as Partners/Supporting Father Involvement programmes (the names refer to the same programme) can lead to improvements in father's psychological and behavioural involvement in family life and reduced couple conflict, both of which are associated with a definition of neglect which encompasses parental failure to respond to a child's basic psychological needs.	abuse or neglect. For more information see the review protocols in Appendix A.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	61		We believe that 'conduct disorder', 'depression' and 'deviant peer engagement' should have been included in this list. The Early Intervention Foundation's review – What works to enhance inter-parental relationships and improve outcomes for children –found that "a child exposed to frequent, intense, and poorly resolved inter-parental conflict is at heightened risk of more negative emotional (e.g. anxiety, depression) and behavioural problems (e.g. conduct problems, antisocial behaviour), which in turn may lead to more negative academic outcomes, deviant peer engagement, substance use/misuse, poor future relationship chances, low employability, heightened interpersonal violence". The draft guideline includes only some of these outcomes, and we believe that it should contain them all.	Thank you for your comment. The detail of these bullets reflect the evidence reviewed. There are NICE guidelines on Antisocial Behaviours and Conduct Disorder in Children and Young People and on Depression in Children and Young People. 'What works to enhance inter-parental relationships and improve outcomes for children' (Harold et al. 2016) does not meet our inclusion criteria, as the population criteria for included studies did not focus specifically on children and young people at risk of, or experiencing abuse and neglect and their families, but has a broader focus on children in situations of parental conflict – which on many occasions would not constitute abuse or neglect. For more information see the review protocols in Appendix A.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	182		In relation to the paragraph beginning 'Five of the studies (Brandon et al. 2008)', we recommend that experience of inter-parental must be included in any meaningful attempt to understand a parent's social history.	Thank you for your comment. The text here reflects the content of the studies reviewed.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	218		We believe that the parenting programmes reviewed by the Early Intervention Foundation (Harold et al., 2016) should be within the remit of this guideline, given that children exposed to frequent, intense and poorly-resolved inter-parental conflict are at risk of neglect. The reviews which the draft guideline is drawing on are relatively old (i.e. (Barlow et al. 2006) (Dawe and Harnett 2007) (Sanders et al. 2004) and hence the guideline as currently drafted fails to reflect more recent review evidence.	Thank you for your comment. The recommended interventions reflect the evidence reviewed by the GC. 'What works to enhance inter-parental relationships and improve outcomes for children' (Harold et al. 2016) does not meet our inclusion criteria, as the population criteria for included studies did not focus specifically on children and young people at risk of, or experiencing abuse and neglect and their families, but has a broader focus on children in situations of parental conflict – which on many occasions would not constitute abuse or neglect. For more information see the review protocols in Appendix A.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	101		We are concerned that findings from a number of studies showing an association/link between parental conflict and neglectful behaviour, or behaviour that effectively indicates neglect (but does not use the term 'neglect' explicitly), have not been drawn on in the drafting of the guideline. For example, there is a positive correlation between parental conflict and child neglect (Turner et al., 2012). In addition, research indicates that inter-parental conflict can negatively impact children's development and well-being through neglectful behaviour (Erel &Burman, 1995; Sturge-Apple et al. 2012, Turner et al., 2012), for example withholding empathy or positive engagement. An observational study of 86 two-parent families with a child (Margolin et al., 2004) showed that marital hostility can limit parents' emotional accessibility to their children. In families with aggression between the parents, marital hostility was associated with lower empathy towards children in fathers, and negative affect towards children in mothers. Furthermore, there is longitudinal evidence that marital conflict can lead to less positive parenting. Schacht et al. (2009) followed 235 families over the course of three years. Fathers' destructive	Thank you for your comment. Thank you for the studies which you have suggested we should consider including as sources of information and data for the guideline. As professional practice in the area of child abuse and neglect is being constantly reviewed and updated, it was decided to have a cut-off point of 2004 in the review protocols for including studies in the guideline. A date cut-off is used to limit the

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				conflict tactics with mothers were associated with less positive parenting, which in turn was associated with children's emotional insecurity. An experimental study of 40 families (Kitzmann, 2000) provides further evidence that martial conflict leads to lower support and engagement of fathers with their son. Neglect is not only evident in negative affect as well as withholding empathy, positive support and parenting, but also in a lower secure child-parent attachment. A longitudinal study of 78 families (Frosch et al., 2000) showed that inter-parental hostility when children are 6 months old predicts less secure attachment to the mother when the children are 3 years old. Marital conflict at 3 years was associated with less secure attachment to both parents. The link between marital conflict at 3 years (and inter-parental hostility at 6 months) and the less secure child-mother attachment was mediated by more hostile parenting behaviour. We feel that not drawing on the findings from these studies results in the draft guideline not adequately recognising the role of inter-parental conflict in child neglect.	volume of data. This date was chosen on the basis of this being the year of publication of the Children Act 2004 which revised the legal framework for how social services and other agencies deal with issues relating to children. For this reason, we would not be able to consider the studies by Errl and Burman (1995), Kitzman (2000) or Frosch et al. (2000) which you have suggested. Other studies which you have suggested were considered for inclusion, but for various reason the reviewing team decided not to include them. • The study by Turner et al (2012)was considered for RQ3 but was excluded on study design (it was not a systematic review or meta-analysis) • Margolin et al (2004) this was not found in our searches but was screened on title and abstract and excluded on study type (not an empirical study) • Sturge-Apple et al. was screened and excluded on outcome (cortisol reactivity, and studies of physical or clinical signs and indicators were specifically excluded from consideration for the guideline). • The study of fathering by Schacht et al. 2009 – this was not found in our search. However, screening on title and abstract suggests this would not have met the criteria for the relevant question (Q3 and 4) because it is not a systematic review or meta-analysis.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	464		Regarding 1.2.9, add the following two bullet points to the list: • They engage in frequent, intense, and poorly resolved interparental conflicts • They (the parents) engage in non-acrimonious but chronic conflict in the context of a relationship that is devoid of warmth or affection	Thank you for your comment. The detail of these bullet points reflect the evidence reviewed.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	469		Regarding, 1.2.31, amend the final bullet point so that it reads: 'Exposure to frightening or traumatic experiences, including domestic abuse, frequent, intense, and poorly resolved interparental conflicts, or non-acrimonious but chronic conflict in the context of a relationship that is devoid of warmth or affection'.	Thank you for your comment. The detail of these bullet points reflect the evidence reviewed.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	471		Regarding 1.2.46, insert the words 'inter-parental conflict' into the first bullet point so that it reads: 'training newly qualified doctors in risk factors for abuse and neglect, such as parental mental health problems, inter-parental conflict, alcohol and substance misuse (and providing top-up training sessions every 6 months)'. Insert a new bullet point into this list: • training new qualified paediatricians, midwives and home visitors to be able to recognise signs of inter-parental conflict in the parents of children they assess	Thank you for your comment. The detail of these bullet points reflect the evidence reviewed.
The Relationships Alliance (Relate, Tavistock Relationships, One Plus One and Marriage Care)	Full	475		Regarding, 1.4.6, add the following bullet point to the list: • improve their co-parenting relationship	Thank you for your comment. The detail of these bullet points reflect the evidence reviewed.
Tees, Esk and Wear Valleys NHS Foundation Trust	general			Question 1: Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. • Resources available for home visiting parenting programmes.	Thank you for your comment which provides helpful context for ongoing implementation work.

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				▯ Resources and skills for attachment based interventions within CAMHS – evidence base, funding. ▯ Training required re trauma focused CBT. ▯ Impact on capacity- without additional resources – increased impact on current waiting lists.	The GC considered the likely resource impact of interventions reviewed, alongside effectiveness evidence and data from economic modelling. They agreed that those featured in the final guideline are aspirational but achievable.
Tees, Esk and Wear Valleys NHS Foundation Trust	Short Version	General	-	Question 2: Would implementation of any of the draft recommendations have significant cost implications? ▯ Cost implications of above. ▯ Having staff trained specifically in safeguarding supervision. ▯ Impact on resources and clinical capacity.	Thank you for your comment which provides helpful context for ongoing implementation work. The GC considered evidence on cost-effectiveness and economic modelling, as well as the potential resource impact of any interventions. If cost-effectiveness evidence or economic modelling was not available, the committee made 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence. 'Consider' means that practitioners should think about providing the intervention, rather than that they must offer it. The committee also took in to account the availability of therapeutic interventions. Whilst it was acknowledged that there would be regional variability in the availability of particular therapeutic interventions, the committee's view was that these interventions are already provided in a number of localities, and the guideline could be used to encourage commissioning and greater consistency of provision. Given all these considerations, the recommendations were felt by the GC to be aspirational but achievable.
Tees, Esk and Wear Valleys NHS Foundation Trust	Short Version	General	-	Question 3: What would help users overcome any challenges? ▯ Integrating CAMHS/Children's services teams for looked after children; children on a child protection plan etc.	Thank you for your comment which provides helpful context for ongoing implementation work.
Tees, Esk and Wear Valleys NHS Foundation Trust	Short Version	General	-	General comment: ▯ It would be helpful to have an update on evidence based interventions on insecure/disorganised attachments.	Thank you for your comment. There is a separate NICE guideline on children's attachment, which is based on the relevant evidence relating to effective interventions.
Tees, Esk and Wear Valleys NHS Foundation Trust	Full Version.	Section 5, page 264	-	**Awareness of Risk:** ▯ Resources to have intensive and consistent inter-professional discourse, in relation to SCRs – especially in view on gaps in workforce staffing and high staff turnovers in specialist CAMHS and in GP services.	Thank you for your comment. The evidence we reviewed that is reported in this section also highlighted that supporting good quality inter-professional discourse was challenging.
Tees, Esk and Wear Valleys NHS Foundation Trust	Full Version.	Section 6, page 265	-	**Care-experienced young people's views of support to address risk of child sexual exploitation:** ▯ Resources to have intensive and consistent discourse to hear " Voice of the Child" – especially in view on gaps in workforce staffing and high staff turnovers in specialist CAMHS, Social Services and in GP services.	Thank you for your comment. The evidence we reviewed that is reported in this section also highlighted that supporting professionals to consistently hear the voice of the child was challenging.
Voice	Full	General	General	As a trade union, representing both teachers and support staff across all stages of education (from nursery to tertiary), Voice welcomes this guidance. It is very comprehensive in scope and the guidance is clearly expressed and based on sound evidence.	Thank you for your comment, and for your support for the guideline.
Voice	Full	General	General	The only concern we have is that the guidance is very unwieldy and so will be difficult to digest. In particular, practitioners may have difficulty navigating the document and finding the appropriate section when faced with an urgent incident. This could be ameliorated by better signposting and also by including hyperlinks (in the electronic version) or cross-references (in the printed version) to facilitate a search of related material. It might also help to divide the guidance into discrete physical units.	Thank you for your comment. There is a shorter version of the guideline (54 pages) which is the version NICE would expect practitioners to refer to. The longer version provides details of all the evidence reviewed for those wishing to know more. To help people to use the guideline and associated materials, NICE has developed an online 'hub' for the guideline and supporting materials. This includes links to

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					other relevant NICE guidelines and statutory guidance.
Voice	Full	General	General	**Re: Q1 – Which areas will have the biggest impact on practice and be challenging to implement?** Austerity has brought about a fragmentation of public services, such that there are now significant gaps in many central services, with a concomitant loss of essential experience and expertise. This means that some of the referral systems are not as efficient as they should be, and collaborative working between different agencies (education, health, social care, youth services and the police) can be fraught with problems, especially in terms of convening meetings (whether physical or virtual) and finding funds to facilitate inter-agency working.	Thank you for your comments which provide useful context to inform ongoing implementation work. The GC considered carefully the wider context in which this guideline sits. The introduction has been updated to communicate more clearly the potential benefits the guideline offers, specifically, identification of the most effective and cost effective interventions to address child abuse and neglect, based on best available evidence.
Voice	Full	General	General	**Re: Q2 – Would implementation of any of the draft recommendations have significant cost implications?** There is a need for agencies to work together collaboratively, but cost-cutting and budget shortfalls can make this very difficult as intra-agency objectives tend to take priority over inter-agency ones and it is often difficult to justify (or trigger a protocol for) spending money beyond the parameters of the individual agencies. Also, where services have been cut back, specialisms may have disappeared and the whole service may be under too much strain to be optimally effective in meeting demand.	Thank you for your comments which provide useful context to inform ongoing implementation work. The GC recognised the challenges and barriers you highlighted. During development of the guideline we searched for and reviewed cost effectiveness evidence and economic modelling for the recommended interventions where available, and considered resource impact. The recommendations therefore aim to help local areas to improve cost effectiveness of local services. If cost-effectiveness evidence or economic modelling was not available, the committee made 'consider' recommendations where they thought it was helpful to highlight interventions shown to be effective by the research evidence. 'Consider' means that practitioners should think about providing the intervention, rather than that they must offer it. We have updated the guideline following consultation to show how it fits with existing guidance such as Working Together 2015, which already places onus on agencies to collaborate.
Voice	Full	General	General	**RE: Q3 – What would help users overcome any challenges?** Adequate funding is needed to maintain and develop essential central public services. Pooling resources between different local authorities may help, although so much has now been out-sourced to private providers that this is now much more difficult than it used to be.	Thank you for your comments which provide useful context to inform ongoing implementation work.
Voice	Full	General	General	**RE: Equality Impact Assessment** We would take issue with the statement that disabled children are not considered to be a particularly vulnerable group. Many case reviews have pointed to the fact that disabled children have been targeted because disability has made them more accessible to abusers or less likely to be able to protect themselves or, in some cases (depending on the particular disability) to report or communicate abuse.	Thank you for your comment. Recommendation 1.2.7 and the Equality Impact Assessment both highlight disabled children as being at increased risk of abuse and neglect.
CIS-ters – surviving rape & sexual abuse	Short	23	1.6.2	Line 2 of 3; delete the words 'if possible'	Thank you for your comment. This wording is based on the guideline committee's consideration of the resource impact of the recommendations. It is intended to recognise that, due to resource contrainsts, it may not always be possible to offer a choice of interventions.
CIS-ters – surviving rape & sexual abuse	Short	23	1.6.3	Sentence –this needs more emphasis; because it is critical when selecting the appropriate pathway for a child or YP. What also needs to be taken into account is the impact of the experience they have had, and ALSO who did it, and what other care givers did or did not do to intervene or stop it etc. This is particularly important when responding to CSA or DV situations.	Thank you for your comment. The recommendations in Section 1.7 are differentiated in terms of the age of the child, and whether they are living with the

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					parent or carer who was responsible for the abuse, or whether they are living with an alternative carer. This aims to support practitioners to select the right intervention for the right child.
CIS-ters – surviving rape & sexual abuse	Short	23	1.6.3	PLUS behaviour and emotional states need more prominence; especially dissociative issues, and hyperarousal and hypo arousal.	Thank you for your comment. Recommendation 1.3.15 is adopted from the NICE guideline on child maltreatment and refers to dissociation. Recommendations 1.3.12 to 1.3.14 are adopted from the NICE guideline on child maltreatment and refer to behavioural and emotional states, although hyper- and hypoarousal are not mentioned specifically.
CIS-ters – surviving rape & sexual abuse	Short	23	1.6.3	PLUS consider the life and rhythm of the child's life when considering interventions/pathways – some might prefer to do something away from school, whilst others prefer at school –so consider these too.	Thank you for your comment. Recommendation 1.1.1 refers to taking a child-centred approach and involving children in decision-making.
CIS-ters – surviving rape & sexual abuse	Short	26	1.6.13 and 1.6.14	What about children who are younger than 5 or older than 17 ?	Thank you for you comment. Recommendations 1.7.4 to 1.7.9 provide recommendations in relation to interventions for children under 5. Young people aged 18 or over do not meet the statutory definition of a child and so are outwith the scope of this guideline.
CIS-ters – surviving rape & sexual abuse	Short	26	1.6.15	Resort this to make it the last choice/offering in the section for CSA –because this was the one that the YP group were so adamant against; plus the feedback from CIS'ters meeting on 12/4/2017 clearly highlighted that CBT, even trauma focused, does not have the longevity that is required. Yes, for a short while after the intervention has ended there will be improvements; but then they begin to degrade thereafter. What is needed is either further research to follow up children 1-2 years after they have had this intervention – or offer something more comprehensive. The timing of this intervention is also critical because a child might be subject to CJS processes, which can take a long time (The children's commissioner report on CSAFE is just about to be launched and mentions the aspect of 'delays' in CJS processes and how these affect the child and the environment they are living in. So, which trauma is being addressed – the trauma of the experience, or the trauma of the CJS/social care processes etc.	Thank you for your comment. The guideline committee considered its recommendation in relation to trauma-focused CBT carefully, particularly given the feedback from the children and young people's expert reference group that they had not always found this helpful. However, the committee decided to retain this recommendation given the effectiveness and cost-effectiveness evidence in support of this intervention. This recommendation aims to address the trauma arising from the abuse. It was the understanding of the committee that new CPS guidance makes clear that participation in legal proceedings should not prevent children from receiving therapy. The recent Children's Commissioner report was published after our evidence review was completed.
CIS-ters – surviving rape & sexual abuse	Short	27	1.6.16 and 1.6.17	The survivors who reviewed this at the CISters session were clear that they were not happy about the age being a barrier to seeking help. They cited the following: If 1.6.16 is on offer to boys and girls; and 1.6.17 is only on offer to girls, does that mean: Boys under the age of 8 are to be offered nothing ? Girls under the age of 6 are to be offered nothing ? The female survivors and trustees also felt that the recommendation discriminates on both age and sex. For example – plus – if there were 3 siblings who needed therapy and were aged Boy – age 5 Boy – age 6 Girl – age 7 Only the girl would be eligible – if worker was to take the guideline literally – which can't be right ? !	Thank you for your comment. The populations for which these interventions are recommended is based on the research evidence. Text has been added to the introduction to Section 1.7 to make this clearer. Recommendations 1.7.17 to 1.7.19 are three possible options for children who have been sexually abused. The intervention recommended in 1.7.17 would be available to girls and boys of all ages. Recommendations 1.7.18 and 1.7.19 then target specific groups, based on the research evidence.
CIS-ters – surviving rape & sexual abuse	Short	27	1.6.16 and 1.6.17	What about siblings who might not (or might have but not yet disclosed because have witnessed already what happens when the bomb goes off in a family) have been abused – they too might have been traumatised by the situation – and need therapy; and yet the final point on 1.6.17 only mentions sessions for non-abusing parent or carer, similar for last bullet point at 1.6.16	Thank you for your comment. The evidence we reviewed did not include any information about therapeutic interventions for non-abused siblings.

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CIS-ters – surviving rape & sexual abuse	Short	27	1.6.16 and 1.6.17	Women at CIS'ters highlighted that many are abused by siblings and that the parent is, therefore, conflicted – and the child victim affected by parental distress. Special consideration needs to be given to this issue – see our point 2 earlier. It is about who did something; and who facilitated something and who did not do something (ie protective failure).	Thank you for your comment. Recommendations 1.7.17 to 1.7.19 also recommend therapeutic responses for the non-abusing carer as part of dealing with this.
CIS-ters – surviving rape & sexual abuse	Short	23-27	1.6	Greater emphasis needs to be given to the work being 'child centred' and not just about an age or gender but what has happened to the child; and what did not happen (failure to protect) and what did that experience DO to the child. It is not about what was done, it is about what it did.	Thank you for your comment. Recommendation 1.1.1 highlights the importance of all work being 'child-centred'.
CIS-ters – surviving rape & sexual abuse	Short	23-27		Women at the CIS'ters event on 12 April 2017 wanted to emphasise that those delivering the interventions need to have an evidenced understanding of trauma informed work; with suitable training. It is not enough to be a health professional or a social worker – they need to have accessed training on the issue of trauma.	Thank you for your comment. We have now made clearer in the introduction to this section that these recommendations are aimed at child mental health professionals.
CIS-ters – surviving rape & sexual abuse	Short	23-27		Why is grooming and the impact of grooming – on not only the child but those around the child overlooked?	Thank you for your comment. Our evidence search did not identify any evidence meeting our criteria in relation to grooming or the impact of grooming.
CIS-ters – surviving rape & sexual abuse	Short	23-27		Women at the CIS'ters event on 12 April 2017 provided, with others who were unable to attend, the following issues (in the days after the meeting on the 12th April): - *Highlight that many children are terrorised into not telling but even if the child can't disclose – being asked by someone (teacher etc) if something is wrong, can help that child survive and keep faith in people until they feel safe enough to tell.* - *The BODY of the abused child will often do the 'talking' for the child. Workers need to look out for recurring rashes or hives, which indicate how much stress or distress might be happening.* - *The experience of abuse can include bullying and interrogation by the abuser – so the worker needs to ensure that when they are talking to the child it doesn't feel like that as well.* - *Workers need to look out for the child who is 'mature beyond their age' who are 'like adults' overly well behaved; not just the disruptive child.* - *Overachieving at school and college is often a sign of someone trying to feel a violent reality at home; although some children will not be able to focus at school.* - *Does the child idealise one or both parents; is the child more special to one parent than the other ?* - *Has the child put on a lot of weight (comfort eating ?)* - *Biggest impact on practice and challenge will be to implement training in how to identify CSA in children and YP (at the moment all of the focus is on CSE). Plus there is a lack of experienced trainers to deliver this sensitive training- not least because services (across sectors) are being cut, meaning that there will be less staff in operational roles to undertake and follow through on these recommendations.* - *For the effective implementation of guidelines – need good* - *quality training (and not on-line) plus effective monitoring of workers who are responding to abuse in children.*	Thank you for your comments. Taking each of your points in turn: - With regard to asking children, recommendation 1.3.5 highlights the importance of exploring any concerns you have with children and young people. - The section on alerting features (see Section 1.3) is intended to give a series of behavioural and non-verbal indicators to help practitioners to identify abuse and neglect. Recommendation 1.1.3 outlines the features of communication with children and young people, including being sensitive and empathic - Recommendation 1.3.13 highlights children who demonstrate excessively 'good' behaviour as of potential concern – this could also link to overachieving at school and college - We did not find any evidence relating to children who idealise parents - With regard to children who are overweight – this evidence base was considered as part of the development of NICE's guideline on child maltreatment. The guideline committee for this guideline thought the evidence was insufficiently strong to support a recommendation. - We did not review evidence regarding effective training for identifying CSA - Recommendation 1.8.5 refers to supervision for professionals.
CIS-ters – surviving rape & sexual abuse	Short	10	6 (box 1)	- *Additional examples of indicators of destress/behavioural and emotional states:* - *If a child has a repetitive word or phrase that they use all the time, especially as if to themselves or in a whisper* - *If a child is found to carry any form of weapon such as a knife, a razor blade, a scalpel or a Stanley knife (for protection)* - *If a child is comfort eating and gaining (silent telling)*	Thank you for your comment. This recommendation is adopted from the NICE guideline on child maltreatment. The behaviours and emotional states referenced in this recommendation are based on the evidence reviewed as part of

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				If a child is an elective mute - *If a child orYP is repeatedly ill and seeks regular medications (to help keep the bad away or make the child feel stronger/invincible)* - *If a child starts attacking other children* - *If a child seeks comfort from anon-human source(animals, blanket, fur coat) – and invests its secret in the object* - *Sleepwalking* - *Leaving school alone before the school day is finished (or lingers rather than leave)* - *If the child suddenly stops taking part in an activity that they had previously enjoyed or been good at (eg drama or sport)* - *If a child doesn't want to go and visit the home of another child (because bad things happen there)* - *If a child has their hands over their mouth frequently, has a watchful or fearful look, chooses words very carefully, keeps themselves distant from other children* - *Very bad nail-biting or chewing inside the mouth;*	developing that guideline, and the professional experience of the guideline committee.
CIS-ters – surviving rape & sexual abuse	Short	23		- *Some children will need more than 30 sessions and others will need less- and all might want to dip in and out at times for more therapy as they go through various developmental ages. Chid needs to say when ready, not a case of 'it is here and if you don't do it then you won't get another chance'.*	Thank you for your comment. The number of sessions stated here are based on the research evidence and consideration of resource impact. However, we would expect practitioners to use their judgement if further sessions are required.
The Survivors Trust	Short	23	1.6.3	We feel that there is a risk that this section does not sufficiently emphasise the impact of the experience on the child or young person which is critical in identifying the needs and appropriate pathway for the child or young person. In addition the relationship of the perpetrator to the child or young person, and the response/s, or lack of, from other care givers also needs to be taken into consideration. This is particularly important when responding to CSA or DV situations.	The recommendations in Section 1.7 are differentiated in terms of whether they are living with the parent or carer who was responsible for the abuse, or whether they are living with an alternative carer. This aims to support practitioners to select the right intervention for the right child.
The Survivors Trust	Short	23	1.6.3	We are concerned that this does not give sufficient prominence to other behaviour and emotional states, for example trauma symptoms, including dissociative states, mood swings, PTSD.	Thank you for your comment. Recommendation 1.3.15 is adopted from the NICE guideline on child maltreatment and refers to dissociation. Recommendations 1.3.12 to 1.3.14 are adopted from the NICE guideline on child maltreatment and refer to behavioural and emotional states, although mood swings and PTSD are not mentioned specifically.
The Survivors Trust	Short	23	1.6.3	The experience of our agencies in delivering services to children and young people is that choice is important in whether an intervention is delivered in school setting in school time or whether it is delivered out of school hours and away from that setting.	Thank you for your comment. Recommendation 1.7.2 refers to giving children and young people a choice of interventions.
The Survivors Trust	Short	26	1.6.13 and 1.6.14	We are very concerned that this excludes children who are under the age of 5 and over the age of 17. Feedback from our member agencies is that they are now receiving referrals through Social Services for many children under the age of 5.	Thank you for you comment. Recommendations 1.7.4 to 1.7.9 provide recommendations in relation to interventions for children under 5. Young people aged 18 or over do not meet the statutory definition of a child and so are outwith the scope of this guideline.
The Survivors Trust	Short	26	1.6.15	Yes, for a short while after the intervention has ended there will be improvements; but then they begin to degrade thereafter. What is needed is either further research to follow up children 1-2 years after they have had this intervention – or offer something more comprehensive. The timing of this intervention is also critical because a child might be subject to CJS processes, which can take a long time (The children's commissioner report on CSAFE is just about to be launched and mentions the aspect of 'delays' in CJS processes and how these affect the child and the environment they are living in. So, which trauma is being addressed –the trauma of the experience, or the trauma of the CJS/social care processes etc.	This recommendation was based on the effectiveness and cost-effectiveness evidence in support of this intervention. The evidence we reviewed included follow-up data for 1 year. The guideline committee took in to account the tendency for effects to fade over time in making the recommendations. It was the understanding of the committee that new CPS guidance makes clear that participation in legal proceedings should not prevent children from receiving therapy. The recent children's commissioner report was published after our review work was completed.
The Survivors Trust	Short	27	1.6.16 and 1.6.17	We are very concerned that this proposal sets out different service access for boys and girls and for children/young people at different ages which will set up barriers to some children and young people accessing services at the point of need and instead there is the risk that services would be offered based on children/young people being a specific age.	Thank you for your comment. The populations for which these interventions are recommended is based on the

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					research evidence. Text has been added to the introduction to Section 1.7 to make this clearer. Recommendations 1.7.17 to 1.7.19 are three possible options for children who have been sexually abused. The intervention recommended in 1.7.17 would be available to girls and boys of all ages. Recommendations 1.7.18 and 1.7.19 then target specific groups, based on the research evidence.
The Survivors Trust	Short	27	1.6.16 and 1.6.17	The experience of our member agencies delivering support and counselling services to families affected by sexual violence and sexual abuse is that in addition to support for non-busing parent/carer, it is also important to offer support to siblings, who may not yet have disclosed their own abuse or who may not have been abused themselves but who are affected by vicarious trauma due to exposure to abuse issues within the family.	Thank you for your comment. The evidence we reviewed did not include any information about therapeutic interventions for non-abused siblings.
The Survivors Trust	short	27	1.6.16 and 1.6.17	We are concerned that more consideration needs to be given to the emotional distress experienced by both the child victim and the parent. NSPCC statistics have highlighted that up to a third of children sexually abused in the family environment are abused by a sibling. In this situation, parents are placed in the position of having to manage both the distress of the child who has been abused and also conflicted feelings around the sibling who is the abuser. Parents can therefore have conflicted feelings around both the child who has been abused and the child who has abused. In some instances, this can lead to a failure to protect or a wish to deny or minimise the experiences of the abused child. The non-abusing parent can also experience guilt at a perceived failure either to protect the child or to respond appropriately.	Thank you for your comment. Part of the aim of the recommended interventions is to help children and their non-abusing parents to cope with the emotional distress following sexual abuse. These recommendations (now 1.7.18 and 1.7.19) also recommend providing support to the non-abusing parent or carer.
The Survivors Trust	short	23-27	1.6	We believe this section needs to give more emphasis to the impact the abuse has had on the child, including the impact on family dynamics, trauma responses, impact on education and socialisation, rather than focusing on age or gender, so that a 'child focused' approach is adopted.	Thank you for your comment. Recommendation 1.1.1 highlights the importance of all work being 'child-centred'.
The Survivors Trust	short	23-27		Research conducted by the University of Suffolk in collaboration with Survivors in Transition, See Me, Hear Me, Believe Me, highlighted the poor response many survivors get from statutory services. We are concerned that training for health professionals or social workers does not currently adequately equip them to work in a trauma informed way and that changes to core curriculums are needed to ensure this.	Thank you for your comment. The therapeutic interventions recommended in Section 1.7 aim to provide a trauma-informed response.
The Survivors Trust	short	23-27		We believe that this section should also include the impact of grooming both on the child and also on the adults in the family. As referred to above, the impact of abuse on family dynamics is profound and is aggravated even more so when a relationship of trust has been created by an abuser. Both the child and adults in the family feel this betrayal and the consequent loss of trust. One of the recognised impacts of sexual abuse in particular is the lack of trust which victims/survivors develop as a result of this breach of boundaries.	Thank you for your comment. Grooming forms part of our definition of sexual abuse, and so would be covered by recommendations 1.7.17 to 1.7.19.
The Survivors Trust	short	23-27		We believe that the most challenging aspect, but also the one with the potential to have the biggest impact on practice will be to implement training on how to identify CSA in children and young people. At the moment there is a huge focus on CSE which doesn't also address CSA. We are also concerned that changes to services will leave fewer trained staff to undertake and ensure with other staff that these recommendations are followed through. Effective training will be crucial to ensuring these guidelines are implemented, delivered face to face as opposed to an online programme. Ongoing monitoring of the implementation of the training and guidelines also needs to be in place.	Thank you for your comment. We did not review evidence regarding effective training for identifying CSA.
The Survivors Trust	short	23		We are concerned that some children and young people may be chaotic in their engagement with services and this could result in them being removed from lists if the response is inflexible and does not recognise that they need additional encouragement to engage. Survivors' Journeys, Survivors' Voices, The Survivors Trust and Rape Crisis England and Wales (2015) highlighted that many survivors talk about wanting to have easy access and return to services. And the value of offering longer term support.	Thank you for your comment. Recommendations 1.7.1 to 1.7.3 aim to encourage a flexible and tailored response to children and young people.
The Survivors Trust	short	General	General	FINALLY – we are surprised at the failure to include 'over-eating' as a potential symptom for children who might be experiencing child abuse. We know from our member agencies that many of the individuals who access their services (children, teens and adults – male and female) began to over-eat as children/teens, as a coping strategy. Therefore to only offer a child with anorexia/bulimia the opportunity to disclose why they might be distressed; and not the same opportunity to a child who is over-eating, is judgemental (in that there is an assumption that it is merely dietary issues) and creates additional barriers to an offer for help if the child is experiencing any form of emotional, verbal or sexual abuse.	Thank you for your comment. The evidence base on the association between being overweight and suffering abuse or neglect was considered as part of the development of NICE's guideline on child maltreatment. The guideline committee for the child maltreatment guideline thought the evidence was insufficiently strong to support a recommendation.

Registered stakeholders

[i] https://www.noo.org.uk/uploads/doc/vid_18987_ECO_poster_SevereObesityFINAL_v2.pdf
[ii] http://www.bmj.com/content/341/bmj.c3074