interventions, including health workers, lay counsellors, peers, and teachers. Interventions predominantly focused on promotion (68%) or prevention, with only two treatment-focused trials.

Perinatal and early childhood interventions predominantly emphasised developmental stimulation (n=21), parenting practices (n=18), psychoeducation related to child health, development, nutrition, or maternal wellbeing (n=19), and responsive caregiving or maternal responsiveness (n=11). In contrast, adolescent interventions primarily targeted psychosocial wellbeing (n=8), positive youth development approaches (n=5), life skills, stress management, or resilience-focused outcomes (n=multiple studies; exact counts varied by domain).

Cognitive behavioural components were present in a minority of interventions (n=7 overall), most commonly embedded within multi-component programmes rather than delivered as stand-alone therapies. The use of standardised developmental and psychosocial outcome measures was common, with the Bayley Scales of Infant and Toddler Development (Second edition: n=6; Third edition: n=11) most frequently used for early childhood outcomes, and the Strengths and Difficulties Questionnaire (n=7) most commonly employed for child and adolescent psychosocial wellbeing.

Conclusion: Over the past decade, South Asia has generated a substantial and methodologically robust body of evidence demonstrating the feasibility and acceptability ofnon-specialist delivered child and adolescent developmental interventions across settings and developmental stages. However, the literature remains heavily weighted toward promotion and prevention, with notable gaps in middle childhood and treatment-focused interventions. Future research should prioritise theoretically explicit, mechanism-informed designs and address under-represented age groups to inform scalable, equitable child mental health strategies in low-resource settings.

Associations of Domestic Violence Types with Self-Harm in Women Using Mental Health Services in South-East London

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Aims: Estimate associations of domestic violence (DV; physical, sexual, emotional, financial) with Emergency Department (ED) attendance for self-harm in women using mental health services.

Methods: We analysed data from the Clinical Record Interactive Search (CRIS),an electronic health record database (EHR) from South London, of women who used South London and Maudsley (SLaM) NHS Trust mental health services. We used a previously developed and validated natural language processing (NLP) algorithm to ascertain identification of DV types occurring within the first year of care and at any time. ED attendances for self-harm were gathered from hospital episodes statistics (HES) data linked tothe EHR database. We adjusted for variables relating to DV and self-harm such as age, ethnicity and psychiatric diagnosis to estimate associations of DV types with ED attendances for self-harm.

Results: Between 2007 and 2020, 240,180 women used services. Missing data was excluded, data from 79,025 women were analysed. Overall, 2670 (3.4%) of women had ED self-harm attendance. The most common DV types recorded at any time were physical (28.8%) and emotional (13.7%). Sexual DV had the strongest association with self-harm. After adjusting for factors that can affect self-harm and DV, the strongest association was for physical DV. The strongest association in the first 12 months after referral was for financial DV.

Conclusion: Women with a history of DV are more likely to use mental health services. Associations between DV types with self-harm are unexplored. Women accessing services who experience DV are more likely to attend hospital due to self-harm than those not experiencing DV. Physical and emotional DV were the most common types. There were associations between self-harm and most DV types. These findings can inform interventions and service improvements.

Treatment Options for Avoidant/Restrictive Food Intake Disorder (ARFID) in Young People with Autism Spectrum Disorder (ASD)

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Aims: To identify effective treatment approaches for ARFID in children and young people with Autism and to highlight the importance of family-based and multidisciplinary interventions to improve nutritional intake, mealtime behaviours, improve quality of life for children and caregivers and reduce long-term clinical burden through early intervention.

Methods: Review of existing literature on ARFID and Autism Spectrum Disorder. Sources included Systematic review, Treatment protocols, Clinical trials and Peer review journals.

Results: Evidence suggests there is high prevalence of ARFID in children with ASD. Parental acceptability and responsibility remains the core and significant area in the treatment journey.

Family based Treatment (FBT-ARFID) is very much effective and is the leading evidence-based manualised treatment for children that are of school-going age and adolescents. It helps the chosen family to re-establish healthy eating in their loved ones and also reduce the symptoms of the disorder–parents take lead in helping children recover with the help of multi-disciplinary approaches.

Family-based treatments and Unified protocol programmes (combination of FBT and CBT) to manage anxiety, food rigidity and sensory sensitivities, make mealtimes less stressful and help with an increase in the oral intake. Many studies have shown that children undergoing FBT have shown progressive gain in weight and also have reduced symptoms, giving parents and family hope in re-feeding their child.

Many school-going children and young adults can also have benefits from individual Cognitive behavioural therapy (CBT). CBT helps people change their thinking patterns and behaviours to cope with changes in mood and help them cope overall.

Conclusion: ARFID and ASD co-occur due to shared sensory, cognitive rigidity and behavioural traits.

Early, individualised treatment can prevent severe nutritional and medical complications. Family-based interventions including family-based therapy and CBT are key to successful outcomes.

Investing in a structured ARFID-Autism service represents a high-impact, cost-effective solution. Combination of Family basedtreatment, early screening, and multi-disciplinary approaches can offer improved clinical outcomes for children and families.