Title registration for a systematic review: Psychosocial interventions for preventing PTSD in children exposed to war and conflict-related violence

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Submitted to the Coordinating Group of:

- [ ] Crime and Justice
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Title of the review
Psychosocial interventions for preventing PTSD in children exposed to war and conflict related violence: a systematic review

Background

DESCRIPTION OF THE CONDITION
It is estimated that one in 10 children (approximately 230 million children) currently live in a war or conflict-affected society and will be exposed to daily violence in their communities (UNICEF, 2016). Some may be forced into violent combat, and many more will experience familial, social and cultural losses (Betancourt, McBain, Newnham, & Brennan, 2013; Betancourt, Meyers-Ohki, Charrow, & Tol, 2013; IASC, 2014; Santa Barbara, 2006). It is generally accepted that children and young people exposed to violence in areas of conflict are at an increased risk of harmful effects, including injury, sexual abuse, disability, illness, and long-term mental health issues or psychological problems.

The harmful psychological effects of war include post-traumatic stress disorder (PTSD), post-traumatic stress symptoms (PTSS), depression and anxiety disorders (Attanayake et al., 2009; Dimitry, 2012; Fasfous, Peralta-Ramírez, & Pérez-García, 2013; Jordans, Tol, Komproe, & de Jong, 2009; Yule et al., 2000) and, in young children, disturbed sleep, disturbed play and somatic symptoms (Slone & Mann, 2016). A meta-analysis of child and adolescent mental health in conflict affected settings estimated that prevalence rates were elevated for PTSD (47%, 17 studies, 95% CI: 35–60%), Depression (43%, four studies, 95% CI: 31–55%) and Anxiety (27% three studies, 95% CI: 21–33%) (Attanayake et al., 2009). This is compared to much lower lifetime prevalence estimates in the general population of, for example, American adolescents of 5% PTSD, 12% depressive disorder, 2.2% generalized anxiety disorder (Merikangas et al., 2010). In young children (age 0-6) exposed to war and conflict related violence prevalence of either PTSD or PTSS ranged from 8 to 45% (Slone & Mann, 2016). PTSD is the most common mental-health condition associated with exposure to war, conflict and political violence. As with adults, children suffering PTSD present with broad categories of post-traumatic stress symptoms (re-experiencing, avoidance/numbing and increased arousal). Younger children may display more overt aggression and destructiveness and re-experiencing symptoms may take the form of re-enacting the experience, repetitive play or frightening dreams. Subjective experience of the event and peritrauma factors, such as perceived severity and proximity have been identified as possible risk factors for developing PTSD after trauma (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). Post-trauma risk factors include low social support, poor family functioning (Trickey et al., 2012) and higher negative posttraumatic cognitions (Punamaki, Palosaari, Diab, Peltonen, & Qouta, 2014). Finally, pre-trauma factors, such as a non-related mental health disorder, age and gender have also been linked to development of PTSD following war and conflict related violence. Girls are likely to experience greater subjective exposure than
boys and older children are more likely to have direct exposure to conflict related violence (Dimitry, 2012).

While PTSD is common in children exposed to war and conflict related violence, it is important to note that not all children exposed to trauma will go on to develop PTSD. Severe distress and fear is a normal reaction to trauma and there is substantial natural recovery in the initial months and years after a traumatic event (Bisson et al., 2010). For example Punamäki et al., (2014) showed that 12% of children aged 10-12 exposed to war in Gaza suffered relatively low amount of post-traumatic stress symptoms in the following year. A further 76% of children had initial high levels of symptoms but recovered within 11 months. A sizeable minority of 12% experienced initial severe levels of post-traumatic stress symptoms which increased over a year. At least a third of individuals who initially develop PTSD retain symptoms for three years or longer(Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). It is important to recognise that immediate intervention may not be necessary, and in the case of critical incident stress debriefing may in fact be harmful(NICE, 2013; Rose, Bisson, Churchill, & Wessely, 2002).

This raises important questions; when, if at all, should intervention be offered after a potentially traumatising event? How can we decide who does and does not need intervention to reduce the risk that PTSD will develop? Can at-risk children be identified, screened and offered appropriate interventions?

**DESCRIPTION OF THE INTERVENTION**

We are interested in psychosocial interventions that aim to prevent PTSD in children exposed to war or conflict related violence. These interventions can take multiple forms, can vary in relation to the context, target and setting in which they are being delivered, and often have more than one intended outcome.

Universal interventions are offered to everyone in a population, regardless of the level of their exposure to war or conflict related violence. Selective interventions are targeted at subpopulations who may be at a higher risk of developing mental disorders, for example, only those directly exposed to war and conflict related violence. Indicated interventions are aimed at those already displaying some symptoms of disorder and who may benefit from intervention to prevent PTSD developing. Examples of interventions include the universal intervention Psychological First Aid (PFA), currently recommended by humanitarian guidelines (Sphere Project, 2004), to reduce distress after a humanitarian disaster through providing practical help, linking to services to meet basic needs for food, shelter and safety, and listening and providing care and comfort; a selective intervention that used mind-body techniques as part of a school based intervention to reduce PTSS among children in Gaza (Staples, Gordon, & Abdel Atti, 2011); and an indicated classroom-based intervention in Indonesia that focused on trauma processing and co-operative play to reduce post-traumatic stress symptoms and anxiety for children aged 8-12 affected by political violence (Tol, Komproe, Susanty, Jordans, & De Jong, 2008).

**HOW THE INTERVENTION MIGHT WORK**
Interventions to prevent the development of PTSD may work on a number of levels, from directly addressing and processing trauma through to improving individual, family or community resiliency and reducing distress e.g. Jordans et al. (2010); Khamis, Macy, and Coignez (2004). Below is a summary of some of the mechanisms through which these interventions aim to bring about positive change.

**Keeping children safe.** Preventative interventions, such as Child Friendly Spaces (CFS), aim first and foremost to protect children from further harm and traumatisation by reducing their exposure to potentially traumatic events, including the victimisation and abuse that children are at high risk of in emergency humanitarian settings. Child Friendly Spaces aim to create spaces where children can play safely, whilst also creating opportunities to access psychosocial support and screening (Ager, Metzler, Vojta, & Savage, 2013).

**Community resiliency and capacity building.** Interventions that aim to build resilience focus on building community capacity through improved child protection, and community level psycho-educational/awareness raising activities and events. Peltonen and Palassari (2013) connect the benefits of resiliency interventions on short-term impacts (e.g., reducing the likelihood of trauma-related symptoms) and long-term impacts (i.e. the child has a resource to draw upon for life), with improved relationships with their family and connectedness to their community. Community level psychosocial interventions encourage groups of participants to reflect on difficult times and aim to develop coping skills to allow them to challenge and face trauma-related experiences in a supportive social environment e.g., Kumakech, Cantor-Graae, Maling, and Bajunirwe (2009). Community level interventions can also help to reduce stigma (Betancourt, Agnew-Blais, Gilman, Williams, & Ellis, 2010).

**Social and community connectedness.** Many psychosocial support programmes include a community component in which children’s engagement in their local community is thought to increase hope, social connectedness and prosocial behaviour, and to reduce externalising symptoms such as aggression by increasing awareness and attachment to the wider social environment. Activities may include community events, volunteer work or public theatre (Constandinides, Kamens, Marshoud, & Flefel, 2011).

**Supporting family structures.** The literature suggests that, in order to be able to withstand the harmful effects of living in a conflict-affected society, it is vital for children to be exposed to loving, secure and consistent relationships with their caregivers (Betancourt, Borisova, et al., 2013; Qouta, Punamäki, & El Sarraj, 2008; Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009). Caregiver-focused support interventions aim to protect dependents from the adverse consequences of experiencing conflict-related harm by improving family structures, for example, improving the relationship between parent and child, increasing parental involvement and reducing the risk of parental stress (see Dybdahl 2001). This may include improved parenting skills, improved attachment behaviours or parental psycho-education, all of which aim to assist parents in meeting the needs of their children and promoting their well-being. Psycho-education for example may work by helping
parents to understand the symptoms of PTSD, how this may manifest in a child and how parents can best support their child after exposure to a traumatic event.

**Peer group support.** Therapies based in groups, often within a psycho-educational or skills based therapeutic model, draw on an added mechanism of change by drawing on peer influence. Group settings are used to normalise experiences, to alleviate shame, to build cooperative behaviours and provide a forum to practice skills (Bolton et al., 2007). Classroom based interventions use much the same rationale, but with the addition of a real world setting to further normalise and integrate learning (Constandinides et al., 2011). These formats are also used given the larger number of beneficiaries that can be reached with few resources (O’Callaghan, McMullen, Shannon, Rafferty, & Black, 2013).

**Individual psycho-education and skills teaching.** Interventions that use psycho-educational techniques attempt to use education, information and insight to protect and promote well-being and to challenge misperceptions and taboos. Providing evidence-based information on traumatic reactions and living through the daily stressors of war is thought to help normalise experiences, to screen for more serious reactive disorders and encourage healthy and adaptive coping responses (Betancourt, Meyers-Ohki, et al., 2013). For example, Individual Psychological First Aid aims to strengthen mental health outcomes immediately after conflict by providing psycho-education on posttraumatic reactions and encouraging positive coping strategies in the immediate aftermath of the potentially traumatic event(s) (Betancourt, Meyers-Ohki, et al., 2013).

**Emotional regulation.** Many psychosocial preventative interventions include teaching the ability to self-regulate emotions during or after a traumatic event occurring using, for example, breathing exercises, help seeking, social connectedness or positive self-talk. For example, Punamaki et al., (2014) evaluated the effectiveness of the psychosocial intervention ‘Teaching Recovery Techniques’ which is based on CBT principles and provides several ways of increasing emotion regulation, expression, and recognition. This in turn can help children to develop effective coping skills, to feel empowered and be able to regulate their emotions using narrative, imagery and psychoeducational techniques.

**Trauma processing.** Psychosocial preventative interventions that incorporate trauma processing techniques aim to facilitate the integration of traumatic memories into autobiographical memory in order to reduce PTSS and the risk of PTSD. Trauma processing is most commonly used to treat PTSD through narrative storytelling, such as in KidNET (Neuner et al., 2008) or imaginal and in vivo exposure to specific distressing, and often intrusive, memories, such as in TF-CBT (Brown et al., 2017). Some interventions have incorporated these techniques for children with PTSS as part of a wider aim of healing, through play and guided imagery (Peltonen & Punamäki, 2010), to help to integrate and assign meaning to traumatic experiences (Apfel & Simon, 1996) and for indicated secondary prevention interventions for children already displaying symptoms of PTSD (Tol et al., 2008).
Cognitive restructuring. Some trauma focused interventions, usually derived from CBT, include the identification and evaluation of unhelpful thoughts and appraisals of traumatic experiences (such as self-blame) in order to help integrate fragmented and intrusive thoughts about traumatic experiences (Peltonen & Punamäki, 2010).

WHY IT IS IMPORTANT TO DO THIS REVIEW
Children living in areas of conflict are at elevated risk of negative mental, emotional and behavioural outcomes, including high rates of post-traumatic stress symptoms (PTSS), and depression and anxiety problems (Attanayake et al., 2009; Dimitry, 2012). There are multiple studies on the immediate impact or war and conflict-related violence on children but few studies on the long-term impacts (Attanayake et al., 2009; Shaw, 2003), or on the impact psychosocial preventative interventions can have. Few reviews explicitly address the mechanisms of change (Betancourt, Borisova, et al., 2013; Brown et al., 2017; Peltonen & Punamäki, 2010).

There is professional debate around which approach is most effective and least harmful to children living in war or conflict-affected societies, and whether only children with a diagnosed condition should be treated (Apfel & Simon, 1996; Betancourt, Borisova, et al., 2013). The inevitable fact of limited resources in these contexts may mean resources are directed to those who are perceived to be in most immediate need, at the expense of ‘inoculating’ all children from potential future problems. What is important, as we have learned from the debriefing trials in adults, is that interventions should not be harmful or inadvertently disable adaptive responses to trauma. It is currently recommended that children exposed to war or conflict-related violence should not be given pharmacological intervention (IASC, 2007, 2014), so psychosocial interventions provide an important alternative response to try to prevent mental health problems developing.

Objectives

To assess the effectiveness of psychosocial interventions for preventing PTSD in young children aged 0 – 11 years old living in war and conflict-affected societies.

Existing reviews

There are a number of relevant existing reviews detailed below. Our review and existing/ongoing reviews differ in two ways. First we will not be limiting our inclusion criteria to studies conducted in low income countries. Second, we will not be limiting our review to randomised controlled trials. Finally, our review will focus on prevention of PTSD rather than treatment.

Purgato et al., (2014) is carrying out an ongoing individual person meta-analysis of interventions for children exposed to traumatic events in LMIC. The review is likely to provide thorough coverage of evidence-based interventions in LMIC and aims to conduct a detailed analysis of mediating and moderating factors. However, it is limited to interventions
in LMIC and so interventions for trauma-exposed youth in high income countries (HIC), such as Northern Ireland, Cyprus and Israel, will not be included. The review also intends to focus on RCTs only and there is a risk that interventions developed and evaluated within the LMIC context may be overlooked. The well conducted trials tend to be based on interventions developed in the west and so by including only RCTs ‘home grown’ interventions may be excluded.

Purgato et al., (2015) is also carrying out a review of psychological therapies for treating mental disorders in low- and middle-income countries affected by humanitarian crises. The review intends to focus only on psychological interventions which treat people who have been formally diagnosed with a mental disorder using a standardised diagnostic tool. Again the review is limited to interventions in LMICs (so will exclude HICs) and will only include RCTs.

Purgato et al., (2016) is carrying out a review of psychological and social interventions for preventing mental disorders in people living in LMICs and who are affected by humanitarian crises. They are not including non-randomized studies. This means they may not capture the interventions being delivered in the challenging context of ongoing conflict and violence with limited resources which precludes the use of RCT designs, for example studies like (Ager et al., 2011; Jordans, Tol, Ndayisaba, & Komproe, 2013; Loughry et al., 2006; Thabet, Vostanis, & Karim, 2005).

Morina et al., (2017) conducted a review looking at RCTs of interventions delivered to young survivors of mass violence in LMIC who experienced PTSD or depression. As with Purgato et al., (2016) the review will exclude children from high income countries.

O’Sullivan, Bosqui and Shannon (2016) reviewed RCTs of both treatment-focused interventions for children with diagnosed disorders and interventions for the prevention of mental disorders or promotion of wellbeing. The review included only RCTs, excluding less robust trials that may have been contextually appropriate.

Brown et al (2017) carried out a systematic review of psychosocial interventions for children and young people who were affected by armed conflict. The review restricted their inclusion criteria to RCTs or controlled trials, focused on studies in LMIC. Our review will not be limited to LMICs.

Other reviews have provided useful narrative summaries of existing interventions but have been limited in their search dates (Barry, Clarke, Jenkins, & Patel, 2013; Betancourt, Borisova, et al., 2013; Forman-Hoffman et al., 2013; Jordans, Pigott, & Tol, 2016; Jordans et al., 2009; Peltonen & Punamäki, 2010), did not focus on children in war- or conflict-affected settings (Barry et al., 2013; Blom & Beltran, 2010; Ehntholt & Yule, 2006; Gillies, Taylor, Gray, O’Brien, & D’Abrew, 2013) or were not systematic reviews (Blom & Beltran, 2010; Ehntholt & Yule, 2006).
Countries affected by war and other crises may not have the resources or be in the position to offer the stable and secure environment needed to achieve the acceptable level of rigour in an RCT. For these reasons, we intend to include both RCTs, quasi-randomised controlled studies and non-randomised studies (NRS) to allow for the possibility of including more culturally- and context-specific interventions developed within LMIC, whilst not excluding HIC from our review.

**Intervention**

Any psychosocial intervention that has an element of reducing PTSS or preventing PTSD and is delivered in any setting (e.g. school, home or community), to children or their caregivers, compared with no intervention or a comparison with another relevant active intervention.

We define psychosocial interventions in this context/setting as any intervention that offers psychological or social support (or both) with a goal of helping to prevent mental disorders developing (in particular PTSD).

Interventions aimed at children affected by one-off acts of terrorism (e.g. 9/11) or a natural disaster will be excluded. We will also exclude interventions whose main focus is to treat PTSD rather than prevent it.

**Population**

Children aged from birth to 11 years, living in a country previously or presently affected by war or conflict.

We are interested in that population which does not have a formal diagnosis of PTSD. As PTSD is the most commonly diagnosed mental health condition for youth in a country affected by war or conflict, we are interested in interventions which aim to protect and support young people from developing this disorder, rather than those which are delivered to those with a formal diagnosis of PTSD.

We will exclude children who have received a formal diagnosis of a mental disorder. We will also exclude children who are refugees or asylum seekers unless they are internally displaced or displaced to another context that remains affected by an armed conflict.

**Outcomes**

We will only accept standardised measures, their culturally specific equivalents, or both.

**Primary outcomes**

1. *Acute stress reactions and post-traumatic stress symptoms. Examples of measures include the Child Post-traumatic Stress Scale (CPSS) (Foa, Johnson, Feeny, &
2. *Adverse effects/outcomes for example stigmatisation, reluctance to seek future treatment, worsening of symptoms/problems.

**Secondary outcomes**

1. Resilience indicators for example hope or pro-social behaviour. Examples of measures include the Children’s Hope Scale (CHS) (Snyder et al., 1997), the SDQ (Goodman, 2001) or the Emotional Regulation Questionnaire for Children (Gullone & Taffe, 2012).

2. Social relationships for example family relationship, peer relationships and attachment security. Examples of measures include the 10-item Security Scale (Kerns, Klepac, & Cole, 1996) which measures children’s attachment to parents.

3. *Internalizing symptoms as a potential overlapping traumatic reaction for example anxiety, depression and culturally specific equivalents. An example measure is the Screen for Child Anxiety Related Disorders, 5-item version (SCARED-5) (Birmaher et al., 1999) (Birmaher et al., 1999).

4. Externalizing symptoms as a potential overlapping traumatic reaction for example aggression, conduct problems, anti-social behaviour and culturally specific equivalents. Example measures include the Child Behaviour Checklist (CBCL) (Achenbach & Rescorla, 2000, 2001), the Strengths and Difficulties Questionnaire (SDQ (Goodman, 2001)), and the African Youth Psychological Assessment (AYPA).

*We will use those outcomes marked with an asterisk (*) to populate the 'Summary of findings' table. If data are insufficient, we will provide a narrative account of the outcomes.

**Study designs**

Randomised controlled trials (RCTs) and quasi-RCTs (where participants are allocated to groups using a quasi-random method such as date of birth or alternate allocation). Quasi-experimental controlled studies with non-random allocation, that is, non-randomised studies (NRS), in which researchers have prospectively allocated participants (or settings, clinics, locations, etc.) to intervention or control conditions we be included.

We will not include studies with historical controls, case control studies, cross-sectional studies or case reports/case series.
References


# Review authors

**Lead review author:** The lead author is the person who develops and co-ordinates the review team, discusses and assigns roles for individual members of the review team, liaises with the editorial base and takes responsibility for the on-going updates of the review.

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Roles and responsibilities

Hanratty will have overall responsibility for the design, conduct and write up of the systematic review. The team will have regular meetings to coordinate progress and ensure that all members contribute to all aspects of the review. However, and within this, the particular expertise and lead contributions of team members will be as follows:

- Content: Hanratty, Neeson, Bosqui, Duffy.
- Systematic review methods: Hanratty, Neeson.
- Statistical analysis: Connolly, Hanratty.
- Information retrieval (searching, screening and data extraction): Hanratty, Neeson, Bosqui, Dunne, Duffy.

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Potential conflicts of interest

None of the review authors have a financial interest in this review. None of them have been involved in the development of interventions on the scope of the present one.

Preliminary timeframe

Note, if the protocol or review is not submitted within six months and 18 months of title registration, respectively, the review area is opened up for other authors.

- Date you plan to submit a draft protocol:
- Date you plan to submit a draft review:
AUTHOR DECLARATION

Authors’ responsibilities
By completing this form, you accept responsibility for preparing, maintaining, and updating the review in accordance with Campbell Collaboration policy. The Coordinating Group will provide as much support as possible to assist with the preparation of the review.

A draft protocol must be submitted to the Coordinating Group within one year of title acceptance. If drafts are not submitted before the agreed deadlines, or if we are unable to contact you for an extended period, the Coordinating Group has the right to de-register the title or transfer the title to alternative authors. The Coordinating Group also has the right to de-register or transfer the title if it does not meet the standards of the Coordinating Group and/or the Campbell Collaboration.

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I understand the commitment required to undertake a Campbell review, and agree to publish in the Campbell Library. Signed on behalf of the authors:

Form completed by: Dr J Hanratty  Date: 22 August 2017