Interventions for child abuse and neglect: title registration for an evidence and gap map

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Submitted to the Coordinating Group of:

- Crime and Justice
- Education
- Disability
- International Development
- Nutrition
- Knowledge Translation and Implementation
- Social Welfare
- Methods
- Other:

Plans to co-register:

- No
- Yes
- Maybe
  - Cochrane
  - Other

Date Submitted: 18 October 2017
Date Revision Submitted: 28 December 2017
Approval Date: 17 January 2018
Publication Date: 17 January 2018
BACKGROUND

What happens in a child’s early years, can have lifelong consequences for the physical, mental and emotional health of human beings. Children experiencing abuse, neglect and other stressors early in life are at risk of developmental delays, physical and mental health problems and of decreased opportunities in their adult life (Pillas et al., 2014).

This has consequences not only for individuals and families but also for society. The total economic costs resulting from all new cases of child maltreatment in the U.S. in 2008 were estimated to be approximately 585 billion dollars (Fang, Brown, Florence, & Mercy, 2012). The global economic burden derived from mental illness is expected to more than double by 2030 (Bloom et al., 2011). And the annual costs of poor quality education preventing children from acquiring basic skills were estimated to be as large as 129 billion USD at a global level in 2014 (UNESCO, 2014).

Simultaneously, there is growing evidence that investments made in providing children with nurturing care, protection and education in due time will convert into health, wellbeing and learning benefits as children grow older and become adults (Britto et al.). Thus, investing in early intervention to decrease or eliminate risk factors in a child’s life and thereby improving child development is an important strategy for ensuring individual, community and society wellbeing. These investments should be made based on the best available evidence on the effectiveness of interventions – policies, programmes or practices – targeting children facing adversity. However, despite a growing evidence base, reflected in e.g. several systematic reviews registered in this area (Besharov & Call, 2016; Dunne, Craig, Connolly, & Winter, 2016; McCalman et al., 2016), the knowledge about what works to enhance and promote the health, wellbeing and learning of young children at risk is still fragmentated and dispersed.

Knowledge production takes place across several sectors (health, social welfare, and education), focuses on various populations (children of different ages, ethnicities, or with different needs), and involves rather diverse methodical approaches (e.g. systematic reviews, primary studies of different designs etc.). To provide a comprehensive overview of existing knowledge in this area and enable the purposeful and targeted commissioning of future research, tailored to the most eminent needs for knowledge and guidance, a mapping of the existing knowledge base is required.

OBJECTIVE

The purpose of this project is to map the existing evidence – and lack thereof - on the effects of interventions that aim to prevent the maltreatment of children at risk, and to reduce the adverse consequences of maltreatment in affected children. Hence, the guiding research question for this EGM is:
What is the prevalence of evidence on the effectiveness of interventions aiming to:

- Prevent the occurrence of maltreatment in children at risk?
- Prevent the recurrence of maltreatment in exposed children?
- Reduce the harm to children’s wellbeing because of actual abuse or neglect?

The output of the project will be an evidence and gap map (EGM).

Evidence and gap maps

While systematic reviews (SRs) aim to identify, assess and summarise research findings from studies on a (narrow) research question, the objective of evidence and gap maps (EGMs) is to provide a picture of the completeness of existing research literature on a given topic. As such, EGMs have a broader scope than SRs, and SRs go further than EGMs in processing the contents of the identified research. Another important difference between EGMs and SRs is how they are disseminated. SRs are disseminated as research reports or journal articles, where the answer to the research question is the key issue for readers. EGMs can also be disseminated as a report or an article, but the more user friendly EGMs display its results in an interactive matrix. Identified studies are plotted in the matrix, so that the user can find evidence, or lack thereof, for his or her particular topic of interest, at a glance (see Primary and Secondary Education Evidence Gap Map for an example of an EGM matrix: http://gapmaps.3ieimpact.org/evidence-maps/primary-and-secondary-education-evidence-gap-map).

EGMs and SRs share many methodological aspects, such as a predefined scope, selection criteria and search strategies. Screening and selection processes are also quite similar in EGMs and SRs. And both approaches to summarised research aspire to identify every relevant study that falls within the scope. Another similarity is that both EGM and SR methods are open and transparent.

Scope

SRs of effectiveness of interventions typically ask a question like: “What is the effect of kinship care placement compared to foster care placement on the safety, permanency, and well-being of children removed from the home for maltreatment?” (Winokur, Holtan, & Batchelder, 2014). The scope of SRs of effects of interventions is usually narrowed down to specific populations, interventions, comparisons and outcomes. EGMs, on the other hand, have a much broader scope and ask questions like: “What good quality evidence exists regarding the prevention and interventions for suicidal and self-harm behaviours among young people?” and “What areas are, and what areas are not, well researched?” (De Silva et al., 2013).

Selection criteria and search strategies

Both EGMs and SRs have predefined inclusion and exclusion criteria describing eligible study designs, populations, interventions and outcomes. The criteria reflect the scope in both cases. Comprehensive search strategies are developed for both SRs and EGMs to increase the likelihood of identifying all relevant studies within the scope.
**Processing the literature**

Important aspects of literature screening and selection processes in both EGMs and SRs are the independent eligibility assessment as a method to reduce the risk of selection bias. Once the body of evidence has been identified and retrieved in full reports, the similarities between EGMs and SRs become fewer.

SR authors extract data and assess study quality for each included study. Further, they combine the findings of the studies in meta-analyses when possible and assess the overall quality of the evidence. EGM authors limit their contents processing to coding each included study according to a predefined and piloted coding scheme.

To summarise, EGMs display the completeness of research literature on a broad topic, while SRs answer specific research questions.

**EXISTING EVIDENCE AND GAP MAPS**

We have identified existing EGMs that approach our scope, but not quite:


- Included 203 studies: 162 single studies and 41 systematic reviews. The target population was young people aged 12-25 years old with a depressive disorder or a risk of developing a depressive disorder. In addition, children down to 6 years of age were targeted for universal prevention interventions.


- Included 44 studies: 38 single studies and 6 systematic reviews. The target population was children, adolescents and young adults aged 6-25 years.


- Included 58 controlled trials and 8 systematic reviews. The target population was young people aged 12-30 years with a psychotic disorder, or at risk of developing a depressive disorder.

- Assesses the evidence available on the effects of adolescent sexual and reproductive health programming in low- and middle-income countries.


- Included evidence on interventions designed to improve access to education and learning outcomes for primary and secondary school children in in low- and middle-income countries.

The existing EGMs cover the topics depression, suicidal and self-harming behaviours, psychosis, sexual and reproductive health, and access to education. The age groups covered are adolescents and school-aged children. None of the EGMs specifically target child maltreatment and children younger than 6 years of age, which is the topic of the present EGM.

**INTERVENTIONS**

The EGM will include any intervention aiming to help children who a) have experienced, or b) are identified (by study authors) as at risk of, abuse or neglect. The interventions should aim to help the children by preventing the occurrence or recurrence of abuse or neglect, or to reduce the adverse consequences of abuse or neglect. The interventions may target the affected child and/or parent/carer individually, in dyads or in groups. Examples of interventions are home visiting programmes (e.g. Nurse Family Partnership (NFP)), parent training (e.g. International Child Development Program (ICDP)), psychoeducation (e.g. Circle of Security (COS)), family support (e.g. counselling, case management, family councils, financial support) and therapeutic interventions (e.g. Parent-Child Interaction Therapy (PCIT), family therapy).

Typically, the interventions are delivered by child welfare or protection services in various settings (e.g. the child’s home, child welfare centre, out-of-home placements), but we will include any service provider in any setting if the aim of the intervention is within our scope. Examples of other settings include: primary and secondary health settings, childcare settings and schools, voluntary sector settings (including sports).

We will not include universal prevention strategies.
**POPULATION**

The target population is children in high-income countries, aged prenatal through twelve, who are at risk of harm to their wellbeing now and in the future as a consequence of actual or potential abuse (emotional, physical or sexual) or neglect (the ongoing failure to meet the child’s basic physical or psychological needs). The terms emotional abuse, physical abuse, sexual abuse and neglect are defined in Appendix A.

Studies that include children aged 13 years or more will only be included if they report data for the age group 0-12 separately.

Eligible studies of interventions for children at risk of maltreatment must report post-intervention occurrence of abuse and/or neglect (Domain 1 in the Quality Assessment Framework below).

We have limited the scope to include children from high-income countries assuming that exposure to and risk of maltreatment vary between developed and developing countries both in prevalence and nature. Also, the availability and types of interventions will vary considerably with the degree of financial stability.

**DIMENSIONS**

The EGM will have two primary dimensions: interventions (rows) and outcomes (columns). Additional dimensions will be:

- age group (0-2, 3-5, 6-11)
- intervention target groups (individual/groups of children, individual/groups of parents/carers, child-parent/carer dyads, individual/groups of service providers)
- systematic review quality (low, moderate, high)
- type of primary study (RCT, non-RCT)
- status of study (completed, ongoing)

In the hard copy of the EGM, multiple 2x2 representations of the EGM will be reported. A copy of the coding form will be included as an annex to the EGM report.

In the online version, the additional dimensions will be possible to use as a filter. The online version will include references to included studies and brief summaries of each study based on the abstract (for primary studies) or plain language summary (for systematic reviews) provided for it.

**OUTCOMES**

The EGM will include studies that report outcomes within the Quality Assessment Framework (QAF). The QAF was developed by Mildon et al. (2015) within an Australian child welfare context. It was adapted from (a) a child wellbeing framework introduced in the US as part of a major federal
The reform of child welfare services initiated by the Obama Administration (U.S. Department of Health and Human Services, 2012) and (b) an associated Framework for Well-Being for Older Youth in Foster Care (Hanson Langford & Badeau, 2013).

The QAF encompasses the three overarching goals of a child welfare system, *child safety*, *permanency* and *wellbeing*. Within these goals there are seven domains:

1. Safety: Protection from maltreatment
2. Permanency: Stability/restrictiveness in living conditions, maintenance of relationships
3. Cognitive Functioning: Academic achievements, school engagement, problem solving and decision-making skill
4. Physical Health and Development: Overall health, BMI, health related risk- avoidance behaviour
5. Mental Health: Internalising, externalising and traumatic stress symptoms, coping resilience, quality of life/subjective wellbeing
6. Social Functioning: Social competence and skills, adaptive behaviours, social relationships and network, family situation
7. Cultural and spiritual identity: Participation (where desired) in knowledge building and cultural activities

In addition, if included studies report costs related to the delivery of tested interventions, their cost-effectiveness or cost-benefits, these will be reported as well.

**STUDY DESIGNS**

The EGM will include randomised controlled trials (RCTs), non-randomised controlled trials and systematic reviews of effects of interventions. Non-randomised controlled trials (NRCTs) are prospective studies where two or more groups of participants receive different interventions (Higgins & Green, 2011). Also, in NRCTs, participants are allocated to groups by some action of researchers.
REFERENCES


# EVIDENCE AND GAP MAP AUTHORS

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ROLES AND RESPONSIBILITIES

• **Content expertise:**

Dr Hege Kornør is a senior researcher at the Regional Centre for Child and Adolescent Mental Health, which also embraces child welfare. Working closely with researchers, service providers and authorities in the child welfare field, as well as producing systematic reviews on the topic, has given her broad insight into central child welfare issues. She is currently a co-editor in the Cochrane Developmental, Psychosocial and Learning Problems group. She will be responsible for the overall content of the EGM, and will received targeted support on an as-needed-basis from Professor Elisabeth Backe-Hansen, who is a member of the project’s advisory board.

• **Systematic review method expertise:**

All authors are experienced systematic reviewers, which means they are proficient in carrying out the various processes in an EGM, such as eligibility screening, quality assessment and coding. The team will receive targeted support on an as-needed-basis from Professor Aron Shlonsky, who is a member of the project’s advisory group.

Dr Hege Kornør will manage the process of screening, coding and quality assessing systematic reviews. Dr Kornør has more than ten years’ experience as a systematic review author, as well as formal training. She is currently a co-editor in the Cochrane Developmental, Psychosocial and Learning Problems group.

Mr John will coordinate the team of screeners, who will support the conduct of this EGM. He works as Evidence Synthesis Specialist, Campbell Collaboration, New Delhi, and is working on methods for systematic reviews of economic analyses of social programs, and works closely with Ministry of Health, Government of India, NGOs, and researchers, on evidence-informed practice and policy. He has over 5 years’ experience in evidence synthesis including skills in using GRADE, AMSTAR, Cochrane Risk of Bias, Ottawa Newcastle Quality Assessment Score, CASP, PRISMA, and CHEERS for review of economic evaluation studies. Mr. John will also lead the component specific to the costs of interventions including cost effectiveness and cost-benefit analyses.

• **EGM methods expertise:**

Bianca Albers is a senior advisor at the Centre for Evidence and Implementation (CEI) and heads CEI’s area for knowledge synthesis. In this role, she currently leads the production of seven different evidence and gap maps commissioned by the NSW Department of Family and Community Services and the VIC Department of Health and Human Services.

Ms Albers has extensive experience in conducting different types of systematic literature reviews for policy and practice use. She has been involved in the production of full systematic reviews, rapid evidence assessments, scoping reviews, reviews of reviews and evidence and gap maps - commissioned among others by the New South Wales Department of Family and Community
Services, the Victorian Department of Justice and Regulation, NSW Kids and Families, Australia’s National Research Organisation for Women’s Safety, The Royal Commission into Institutional Responses to Child Sexual Abuse, the World Health Organisation, and Social Ventures Australia. She also has tutored Social Work students at the University of Melbourne in conducting scoping reviews.

- **Information retrieval expertise:**

  Ms Brynhildur Axelsdottir is Head of Library at the Regional Centre for Child and Adolescent Mental Health (RBUP). She has many years’ experience in conducting systematic searches for RBUP’s researchers in the field of child and adolescent mental health and welfare.

  Ms Sólvi Biedilæ is a specialist librarian with many years’ experience in conducting systematic searches for RBUP’s researchers in the field of child and adolescent mental health and welfare.

  Both Ms Axelsdottir and Ms Biedilæ are part-time students for a Master’s degree in Evidence-based practice at Bergen University College.

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**FUNDING**

The EGM will be self-funded.

**POTENTIAL CONFLICTS OF INTEREST**

No conflicts of interest.

**PRELIMINARY TIMEFRAME**

**Phase 1: Systematic reviews**

- 1 June 2017: Literature search completed
- 1 September 2017: Study inclusion completed
- 30 September 2017: Quality assessment and coding completed
- 1 November 2017: Draft EGM submitted

**Phase 2: Primary studies**

- 1 October 2017: Literature search completed
- 1 December 2017: Titles and abstracts screened
- 15 January 2018: Full text reports screened
- 1 March 2018: Coding completed
- 1 May 2018: Draft EGM submitted
APPENDIX A. GLOSSARY

Physical abuse  A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse  The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse  Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect  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 caregivers); or
• ensure access to appropriate medical care or treatment.
It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

Source: Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children;
(HM Government, England)