Review of the evidence for effectiveness of programmes to prevent child maltreatment

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1. Methodological considerations
2. Sources of evidence
3. Early childhood home visitation programmes (rel. level)
4. Parent education programmes (relationship level)
5. CSA prevention programmes (individual level)
6. Abusive head trauma prevention programmes (ind. level)
7. Media campaigns (societal level)
8. Other types of programmes
9. Transportability and cross-cultural adaptation
10. Conclusion
1. Methodological considerations

- Focus only on primary prevention programmes
  - High prevalence of CM & severe life-long consequences
  - Only 5-10% (UK, USA), 0.3% in Hong Kong of cases reported to authorities
  - Easier & cheaper and more effective to prevent than remedy effects

- Hierarchy of evidence: SR (MA) & SR²/RCTs/NRCTs/etc. → ????

- Independent evaluations → smaller effect sizes
  - Petrosino and Soydan (2005): Found impressive positive effects in crime-prevention studies conducted by developers-as-evaluators, but no effects in independent trials.

- Outcomes measures: direct, proxy, or risk factors

- Difficulty of identifying effective components of complex interventions → well-specified programme theory
2. Sources of evidence

For each type:
1. What it consists of
2. How effective it is
3. A few examples

Recent searches for new SRs and studies!!! NOT SYSTEMATIC!!! To be published this year
**Results from Mikton and Butchart, 2009**

- Based on 26 reviews and 298 studies

- Effective ≥ 2 high-quality trials demonstrating effectiveness
- Promising = 1 high-quality trial demonstrating effectiveness
- Insufficient and/or mixed evidence

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*Not a single type of programme effective for preventing actual CM*
Results from MacMillan et al, 2009

- Home-visiting programmes are not uniformly effective in reducing child physical abuse, neglect, and outcomes such as injuries; those that have shown benefits are the Nurse–Family Partnership (best evidence) and Early Start
- The Triple P—Positive Parenting Program has shown positive effects on maltreatment and associated outcomes, but further assessment and replication are needed
- Hospital-based educational programmes to prevent abusive head trauma and enhanced paediatric care for families of children at risk of physical abuse and neglect show promise but require further assessment
- School-based educational programmes improve children’s knowledge and protective behaviours; whether they prevent sexual abuse is unknown
3. Early childhood home visitation programmes

What are they?

• "Trained personnel visit parents and children regularly in their homes and provide support, education and information to prevent child maltreatment. They also seek to improve child health and parental caregiving abilities."
• Visits from a few months to two or more years.
• Target mainly CPA, CN, and CEA
3. Early childhood home visitation programmes

How effective are they?

• 17/26 reviews – 149 studies

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• New SRs or new studies since 2008?

• Selph et al., 2013: 10 RCTs of early childhood home visitation, some positive results (particularly Lowell et al. 2011 – reduction in CPS reports), although results were inconsistent

• Peacock et al., 2013: 6 RCTs of early childhood home visitation, one positive result, but outcome "self-reported harsh-parenting", rather that CM

→ Conclusion revised: "effective" for direct measure
Example 1: Nurse Family Partnership – USA

- Nurses visit homes of low-income first-time mothers and provide prenatal health advice, support, child development education, life coaching
- Aim: improve health, well-being, self-sufficiency of low-income first-time mothers and their children and prevent CM
- 16\textsuperscript{th} week of pregnancy $\rightarrow$ 2 years (50X)
- 15-year follow-up of RCT: CM reduced by 48% (Olds et al. 1997)
- Being scaled up in many HMIC
- Cost: US$ 8000-9000
- Benefit/cost: 2.88
Example 2: Child First – USA

- Child & Family Interagency, Resource, Support, & Training

2 components:

1. Home-based, psychotherapeutic, parent–child intervention embedded in
2. A system of care approach to provide comprehensive, integrated services and supports to the child and family;

Aim: to enhance nurturing, responsive parent–child interactions and promote positive social-emotional and cognitive development.

Children 6-36 months at enrolment; 22 weeks; mean of 24 "contacts"

3-year follow-up of RCT: CPS reports ↘ 10% (Lowell et al., 2011).

Cost: psychotherapeutic and care coordination: US$ 4'000

Cost of services as result of new linkages with community services currently unknown
4. Parent education programmes

What are they?

• "Usually centre-based and delivered in groups, these programmes aim to prevent child maltreatment by improving parents’ child-rearing skills, increasing parental knowledge of child development, and encouraging positive child management strategies."

• Can target many different outcomes, in addition to CM:
  • Healthy physical development; diet and nutrition; immunization; early cognitive development; behavioural and emotional regulation; internalizing/externalizing disorders; language skills; social competence, etc.

• Target mainly CPA, CN, and CEA
4. Parent education programmes

How effective are they?

• 7/26 reviews – 46 studies

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• New SR & important new studies since 2008?
  • SR: Knerr et al. (2013): *Improving Positive Parenting Skills and Reducing Harsh and Abusive Parenting in LMIC: A Systematic Review of 12 RCTs*: "can improve parent child relationships & reduce negative parenting practices – both of which are protective factors for CM"
  • However, only 1 study used a direct measure of CM and found no cases of abuse in either group
  • Study: Prinz et al. (2009): Triple P - effective at reducing CM

→ Conclusion revised: "effective" for direct measure (?)
**Example: Positive Parenting Programme (Triple P)**

<table>
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<tr>
<th>Five levels of Triple P</th>
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<tr>
<td><strong>Level 1: Universal Triple P</strong></td>
<td>Media and informational strategies</td>
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<td><strong>Level 2: Selected Triple P</strong></td>
<td>Brief and flexible consultations with individual parents, parenting seminars with large groups of parents, or both</td>
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<td><strong>Level 3: Primary care Triple P</strong></td>
<td>Four brief consultations incorporating active skills training and use of parenting tip sheets</td>
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<tr>
<td><strong>Level 4: Standard &amp; group Triple P</strong></td>
<td>A 10-session programme with individual families using active skills training, home visits, or clinic observation sessions, or an 8-session group-administered programme using observation, discussion, practice, and feedback plus three telephone 15–30 minute follow-up sessions</td>
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<tr>
<td><strong>Level 5: Enhanced Triple P</strong></td>
<td>An augmented version of level 4</td>
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**Cost:** Average of $34 per child for each of the five levels (Mihalopoulos, 2007)
Example: Triple P evaluation

- Cluster RCT in 18 counties in South Carolina: significantly reduced injury and child maltreatment (Prinz et al. 2009)
  
  - For every 100,000 children under 8-years-old:
    - 688 fewer maltreatment cases
    - 240 less out-of-home placements
    - 60 fewer hospital ED cases
5. CSA prevention programmes

What are they?
• Universal programmes delivered in schools
• Aim: build children’s knowledge about CSA and capacity to protect themselves.
• Typical components:
  • Recognizing child sexual abuse and other types of abuse
  • Distinguishing between appropriate and inappropriate touching
  • Telling the difference between good and bad secrets
  • Saying “no” or avoiding unwanted approaches,
  • Telling an adult and know that they were not to blame

→ transfer knowledge and self-protective behaviours to real-life situations.
5. CSA prevention programmes

How effective are they?

- 11/26 reviews – 74 studies

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- New SR & important new studies since 2008?
  - SR by Topping and Barron, 2009 → same conclusion

- Unanimous conclusion:
  - Effective at strengthening knowledge and protective factors against this type of abuse
  - Evidence whether they reduce actual sexual abuse is lacking.
  - Two studies that measured future sexual abuse as an outcome → reported mixed results.

→ Conclusion stands
6. Abusive head trauma prevention

What are they?

• Interventions to prevent abusive head trauma, also referred to as shaken baby syndrome, shaken infant syndrome and inflicted traumatic brain injury.
• Inconsolable crying the most common trigger
• SBS → 13%–30% mortality rate and significant neurologic impairments in ½ of survivors.
• Programmes typically hospital-based, parent education programme.
6. Abusive head trauma prevention

How effective are they?

- 3/26 reviews – 4 studies

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New SR & important new studies since 2008?

- Altman et al., 2011: "Parent education by maternity nurses and prevention of AHT" (USA) → 75% reduction in AHT, but "historical control period"
- Fujiwara et al., 2012 (Japan), Stewart et al., 2012 (UK) → reduction of risk factors

→ Conclusion:
  - Direct measures: conclusion stands (weak study design)
  - Risk factor: conclusion revised: effective
Example: Abusive head trauma prevention evaluation

• Regional hospital-based parent education programme in NY state targeted all new parents prior to discharge

• Components:
  • Parent Education: nurses administered a parent education programme in maternity and neonatal intensive care units
  • Commitment Statement: parents signed statement that they had received the information and understood it.
  • Follow-up Survey: could they recall the information

• 47% incidence of AHT
• Comparisons: historical control and neighbouring state
• Costs ~ US$ 10 per infant
  • Dias et al. 2005
7. Media campaigns
7. Media campaigns

What are they?

- Campaigns that disseminate messages among the general population using channels such as television, radio, printed materials and the internet.

- Aims:
  - Raising awareness of child abuse
  - Promoting positive parenting practices
  - Changing social norms regarding the acceptance of abusive behaviour
  - Encouraging the reporting of maltreatment.

- Modest benefits in addressing a wide range of health-related attitudes and behaviours
7. Media campaigns

How effective are they?

• 3/26 reviews – 5 studies

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• New SR & important new studies since 2008?
• Not much…

→ Conclusion stands
Several waves of nationwide child abuse multi-media public awareness and educational campaigns in the USA in the late 1980s and early 1990s:

→ Awareness of CM grew from 10% to 90%
→ More sophisticated understanding of CM (types, causes)
→ Reductions in both corporal punishment and verbal forms of aggression by parents, according to parents participating in polls
→ But, proportion of parents who report hitting their child with an object or injuring their child in the course of “normal discipline” remained constant

→ evidence mixed
  • Daro and McCurdy, 2007
8. Other types of programmes – all in USA

- Safe Environment for Every Kid (SEEK)
  - Risk assessment & intervention for CM in pediatric clinics (USA)
  - Effective for direct measures (Dubowitz et al. 2009, 2012)

- Multi-component interventions
  - Family support, pre-school education, parenting skills, child care
  - Promising for direct measures

- Community interventions
  - Enhance community capacity, promote collective responsibility
  - Some evidence of effectiveness (Daro and Dodge, 2009)

- Support and mutual aid groups for parents
  - Insufficient and mixed

- Poverty reduction measures
  - Mixed evidence
9. Transportability and cross-cultural adaptation

Fig. 1. Distribution by country of outcome evaluations in a review of child maltreatment interventions.

% of publications ($n = 298$)

EB approaches – culturally specific form of knowledge production?

VAC Evaluation Challenge Fund
9. Transportability and cross-cultural adaptation

- A host of factors may weaken or even cancel out the effects of the programme in new settings, so critical to:
  - a) adapt and test the effectiveness of programmes
  - b) build up the evidence-base from LMIC

- Factors:
  - Language and literacy
  - Diversity in family structure
  - Poverty and other pressures
  - Capacity and readiness (e.g. trained staff, infrastructure, funds)
  - Community support and engagement
  - Practical considerations
9. Transportability and cross-cultural adaptation

- Six recent meta-analyses cast some doubt on need for extensive adaptation
- Found that unadapted programmes worked as well and sometimes better in new setting (country, culture)
- Gardner et al. (2013):
  - “The common and plausible view that parenting interventions are most effective when transported to countries that are more similar culturally, and in terms of service provision, to those in which they were developed, is not supported by the findings of this review. Neither do these interventions appear necessarily to need extensive adaptation when transported across countries.”
## 10. Conclusion

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**ORIGINAL**
10. Conclusion

- Evidence-base increasing
- EB CMP still young field – 20 years old
- But…picture not as rosy as appears:
  1. Little evidence for the effectiveness of community and societal level programmes & policies
  2. For some types → only a 1 or 2 specific programmes work
  3. Evidence-base from LMIC very thin
  4. Many programmes costly
  5. Capacity to implement EB CMP programmes often lacking
  6. Most evaluations not independently conducted!
- Case for evidence-based approaches: ethical – to do as much good as possible with scarce resources
- "Taking action and generating evidence"
People have been harmed – sometimes on a massive scale – by failure to prepare and take account of scientifically defensible reviews of reliable evidence about the effects of interventions" (Chalmers et al., 2005)


http://www.facebook.com/whoviolenceprevention

http://twitter.com/WHOviolencenews