Child Maltreatment Systematic Review Summary

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Introduction

Child maltreatment is a major global public health problem, with many potential physical, emotional and relational consequences across the lifespan: injury and attachment disorders beginning in infancy; academic failure and poor peer relationships in childhood; substance abuse in adolescence; relationship problems and risk for maltreatment of one's own children in adulthood; and mental health symptoms and disorders across childhood, adolescence, and adulthood.[1–7] Official statistics seriously underestimate the occurrence of child maltreatment. Self-reports of child maltreatment are considered more accurate, but still likely underestimate occurrence rates. In Canada, the Canadian Incidence Study (CIS) of Reported Child Abuse and Neglect has provided information about the estimated number of maltreatment-related investigations every five years since 1998. Findings from the most recent cycle (2008) indicate that the incidence was 39.16 per 1,000 children.[8] The incidence for substantiated maltreatment was 14.19 per 1,000 children. The primary categories of substantiated maltreatment based on CIS-2008 data were as follows: physical abuse (20%), sexual abuse (3%), neglect (34%), emotional maltreatment (9%) and exposure to intimate partner violence (34%).

Our review group systematically evaluated and synthesized the available evidence, including following a modified GRADE[9] process with the VEGA Evidence Review Group's topic experts, to arrive at guidance statements for identification, initial response and intervention/referral. The child maltreatment Evidence Review Group also attempted to contextualize the guidance for Canada, having discussions that then continued with the National Guidance and Implementation Committee (NGIC).

In some cases, where evidence was lacking, we used the mechanism of good practice statements.[10] These statements are intended to guide healthcare and social service providers in identifying and initially responding to children exposed to maltreatment based on the best available evidence and expert clinical judgment. Given the interrelated nature of family violence—including child maltreatment, children's exposure to intimate partner violence, and intimate partner violence—we have made links across these guidance statements wherever possible.

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Summary of Guidance for Child Maltreatment Identification and Response

Intervention	Recommendation	Comments
Recommended		
Recognition of child maltreatment • Case-finding	Identification through case-finding (defined below) is recommended. Initial response to a positive identification should involve providing safe and supportive responses.	Good practice statements See the Children's Exposure to Intimate Partner Violence and Intimate Partner Violence Systematic Review Summary documents for similar recommendations for these exposures.
Counselling/therapy interventions • Cognitive behavioural therapy with a trauma focus	Consider cognitive behavioural therapy with a trauma focus (CBT-TF) for children and adolescents (ages 2–17) who have been sexually abused and are experiencing symptoms of post-traumatic stress disorder (PTSD). Where possible, therapy sessions for children and non-offending caregivers (and some joint sessions) are recommended, but child-only CBT-TF is also effective.	See the Children's Exposure to Intimate Partner Violence Systematic Review Summary document for recommended interventions for this exposure.
Parenting interventions, clinic/ community • Parent-child interaction therapy	Consider parent-child interaction therapy (PCIT) for families of children (ages 2–12 years) who have been physically abused or neglected and are experiencing externalizing problems (such as oppositional or acting-out behaviour), or whose caregivers have harsh parenting interactions or high emotional reactivity. PCIT of at least 12 weeks in duration is recommended. This intervention has not been studied with children exposed to sexual abuse and so it is **not** recommended for children with this exposure.	
Cannot Recommend For or Against		
Parenting interventions, home-based • SafeCare	There is insufficient evidence to recommend either for or against SafeCare.	

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Not recommended		
Counselling/therapy interventions	The following counselling/therapy interventions are not recommended at this time: • ***For exposure to child maltreatment*** (multi-abuse): Project Chrysalis, child-parent psychotherapy, multifamily group therapy, CBT, play therapy • ***For exposure to sexual abuse:*** CBT alone (i.e., CBT that is not trauma-focused), stress inoculation and gradual exposure alone, prolonged exposure alone, Risk Reduction through Family Therapy, EMDR (eye movement desensitization and reprocessing) • ***For exposure to physical abuse/ neglect:*** CBT alone, play therapy, cognitive behavioural training • ***For exposure to neglect specifically:*** dyadic music therapy	
Parenting interventions, clinic/community	The following parenting interventions, typically delivered in the clinic/ community, are **not** recommended at this time: • ***For exposure to child maltreatment*** (multi-abuse): stress management • ***For exposure to sexual abuse:*** family network meetings with group work • ***For exposure to neglect specifically:*** Families Actively Improving Relationships Program (FAIR)	
Parenting interventions, home-based	The following parenting interventions, typically delivered as intensive home-based services, are not recommended at this time: • ***For exposure to child maltreatment*** (i.e., multi-abuse): promoting first relationships, attachment-oriented home visits, psychoeducational home visits, psychoeducational parenting interventions, multisystemic therapy, attachment & biobehavioural catch-up • ***For exposure to physical abuse and neglect:*** home visits by public health nurses, multisystemic therapy, Project Support, Internet-based Interacting Together Everyday, Recovery After Childhood TBI (In-TERACT)	

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Child-focused skills training	The following child-focused skills training are not recommended at this time: • For exposure to physical abuse and neglect: resilient peer treatment	
Other evidence-based interventions	Following an assessment by a qualified provider, children exposed to maltreatment may need to be referred to evidence-based treatments for specific symptoms or conditions (e.g., depression) or other concerns (e.g., substance use). At this time, there is insufficient evidence to refer children exposed to maltreatment to any other interventions simply on the basis of this exposure. Referrals to interventions should be based on an assessment of the needs of the individual.	Treatment should be in accordance with WHO mhGAP intervention guidelines[11] and/or national or profession-specific practice guidelines, delivered by professionals with a good understanding of child maltreatment and its consequences.

1. Recognition of Child Maltreatment

The following good practice statement should guide healthcare and social service providers in identifying children exposed to maltreatment. This statement amends the World Health Organization's recommendation about identifying children exposed to maltreatment, as published in the Mental Health Gap Action Programme (mhGAP) update.[11]

The potential benefits of identifying children exposed to maltreatment are complex and may only be realized when identified by a trained healthcare or social service provider in a safe manner. Providers are encouraged to review VEGA's Family Violence Education Resources for guidance on safely inquiring about maltreatment (e.g., private space in the service setting) and strategies to safely respond to any disclosures of maltreatment.

a) Identification

Two main approaches to identifying children exposed to maltreatment, screening and case-finding, are often contrasted with each other. Screening involves applying a standard set of criteria to evaluate for potential child maltreatment in all presenting children (or a subset of children). Case-finding, alternatively, requires that clinicians are alert to the signs and symptoms of child maltreatment. Instead of using standardized tools or questions, case-finding entails clinicians asking the child about their potential child maltreatment exposure in a way that is tailored to their presentation.

Recommendation

Healthcare and social service providers should, without putting the child at increased risk, ask about child maltreatment when potential indicators are present, including:

1) signs and symptoms in the child (e.g., injury, depression);
2) behavioural and emotional indicators in the child (e.g., markedly oppositional behaviour) or

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caregiver (e.g., caregiver fails to follow up on treatment); or

3) evidence-based risk factors in the caregiver (e.g., alcohol/drug misuse) or situation (e.g., high family stress).

If exposure to child maltreatment is suspected or confirmed, in addition to following through with mandatory reporting obligations, a qualified professional's assessment is required, followed by a referral to evidence-based interventions and subsequent follow up. Universal screening of child maltreatment is not recommended based on available evidence.

See the Children's Exposure to Intimate Partner Violence and Intimate Partner Violence Systematic Review Summary Documents for similar recommendations for these exposures.

Summary of the evidence

Evidence supporting the efficacy of strategies for detecting maltreatment of children and youth within the context of mental health and developmental assessment is sparse and inconclusive. No studies have evaluated the performance of measures in predicting referrals and health outcomes. Furthermore, identified screening tools still cannot identify all maltreated children and many children are falsely identified by these tools. However, it is generally agreed that it is important for healthcare providers to detect child maltreatment. It is also recognized that assessing child maltreatment requires a clinician who is competent enough to ask the right questions and to respond appropriately.

2. Referral Pathways for Child Maltreatment

Below we review interventions specific to child maltreatment. Providers should also consider other evidence-based interventions if the assessment of the child identifies other mental health symptoms or disorders (e.g., depression).

a) Counselling/Therapy Interventions

Recommendation

Consider cognitive behavioural therapy with a trauma focus for children and adolescents (ages 2–17) who have been sexually abused and are experiencing symptoms of PTSD. Where possible, therapy sessions for children and non-offending caregivers (and some joint sessions) are recommended, but child-only CBT-TF is also effective. (Conditional recommendation for intervention; the body of evidence was rated as moderate certainty.)

On the basis of exposure to child maltreatment alone, there is insufficient evidence to recommend other counselling/therapy interventions, such as CBT alone for other maltreatment exposures, Project Chrysalis, child-parent psychotherapy, multifamily group therapy, play therapy, stress inoculation training alone, prolonged exposure alone, Risk Reduction through Family Therapy, EMDR, cognitive behavioural training, or dyadic music therapy. Note that this is a conditional recommendation against these interventions on the basis of *exposure to maltreatment alone*; however, the effectiveness of these interventions for specific symptoms (e.g., depression) or problems (e.g., substance use and addiction) is outside of the scope of this review. Providers should also consult relevant practice guidelines about other evidence-based interventions for

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specific symptoms and problems experienced by children. (Conditional recommendation against these interventions; the body of evidence was rated as very low certainty.)

Remarks[ll]

CBT-TF is a manualized therapy that addresses the impact of traumatic events. Originally developed for children who had been sexually abused and their non-offending caretakers, this therapy has been expanded to treat complex trauma, children who have been exposed to intimate partner violence, and traumatic loss. While CBT-TF with cognitive processing therapy draws on a number of theoretical principles (family systems, neurobiology, developmental theory, attachment theory and client-centred humanistic treatment principles), "the essential theoretical underpinnings of TF-CBT are cognitive-behavioral principles; specifically, the ability to reflect on, make connections among and change maladaptive trauma-related thoughts, feelings, and behaviors."[12] TF-CBT was originally conceived as a child-parent therapy, but the creators indicate that the therapy has been successful as a child-only therapy. Adaptations have also been made to test this therapy in a group setting. Other counselling/therapy interventions for child maltreatment can take various forms—they may vary in intensity/duration, they may occur in an individual or a group setting, they may be provided by clinical psychologists, social workers or others trained in counselling, they make take place in various settings (e.g., community vs. institution), and they may also vary on whether intervention is provided to the child only or to child/parent dyads.

The costs of counselling/therapy interventions are likely moderate and depend on who is providing the service and where the service is provided, although the certainty of this is very low. Overall cost effectiveness seems to favour providing CBT-TF. For all other counselling/therapy interventions, a cost versus benefits analysis does not appear to favour the provision of specific child maltreatment-focused counselling/therapy interventions. Note that this statement refers to the maltreatment-specific counselling/therapy interventions summarized in this document. As discussed above, providers should consider other evidence-based interventions if the assessment of the child identifies other mental health symptoms or disorders (e.g., depression).

Overall equity is probably reduced since specific counselling/therapy interventions for child maltreatment are not widely available and would likely accrue costs to patients (e.g., transportation to specialized facilities, costs of therapists not covered by provincial or other insurance). Counselling/therapy interventions—including CBT-TF—are likely acceptable to most clients (children and caregivers) and providers (those referring to and those providing intervention/service), although counselling/therapy options should be discussed fully with the child (where appropriate) and caregiver and account for their preferences and values. Counselling/therapy interventions, including CBT-TF, were considered to be relatively feasible in the Canadian context. However, the feasibility of "individual psychotherapy" was unknown, given that this approach is not manualized and it is hard to determine what would make the intervention effective or not for children exposed to maltreatment.
See the Children's Exposure to Intimate Partner Violence Systematic Review Summary for counselling/therapy recommendations specific to this exposure.

[ll] "Remarks" summarize key points related to scope, acceptability, equity and other considerations discussed by the Evidence Review Group.

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Summary of the evidence

We have moderate certainty of evidence in CBT-TF versus non-CBT therapies for children and caregivers, but very low certainty of evidence for other forms of counselling/therapy, such as CBT-TF for children only, child and parent psychotherapy, multifamily group therapy, CBT, cognitive behavioural training, play therapy, stress inoculation and gradual exposure alone, prolonged exposure alone, Risk Reduction through Family Therapy, EMDR and dyadic music therapy. Four RCTs[13–16] were pooled in order to generate moderate certainty of evidence about CBT-TF for boys and girls (ages 2–15) exposed to sexual abuse and their caregivers. This evidence suggests that at post-treatment, CBT-TF enables moderate reductions in in PTSD symptoms, depression symptoms and overall internalizing symptoms, as well as small reductions in overall externalizing symptoms and anxiety symptoms. At a 24-month follow-up, large reductions in PTSD symptoms and externalizing symptoms were seen, as well as small reductions in depression symptoms. Another six RCTs[17–22] examined CBT-TF in ways that were not pooled in order to identify effects specified by gender and iterations of CBT-TF where possible (e.g., child-only CBT-TF, CBT-TF for girls only). Analyses specific to this set of evidence suggests that we have very low certainty that CBT-TF in a child-only iteration or delivered in group format shows similar effects (reduction in PTSD, depression, anxiety, internalizing and externalizing symptoms).

Numerous single RCTs have shown promising results for other forms of counselling/therapy, suggesting that more research is needed. For example, at post-treatment, preschooler-parent psychotherapy for children (average age of four years) exposed to maltreatment seemed to lead to large improvements in positive parent-child interaction compared to a community control[23]; prolonged exposure therapy (vs. supportive counselling) for adolescent girls (ages 13–18) exposed to sexual abuse resulted in large reductions in PTSD and depression symptoms[24]; and Risk Reduction through Family Therapy (vs. treatment as usual) for adolescents (ages 13–17) exposed to sexual abuse may lead to large reductions in PTSD, depression and internalizing symptoms, as well as small reductions in externalizing symptoms.[25]

RCTs for other counselling/therapy interventions (e.g., Project Chrysalis,[26] multifamily group therapy,[27] CBT,[28] play therapy,[29] stress inoculation training[30]) show limited, mixed or inconclusive results. Also, RCTs evaluating the effectiveness of EMDR for children exposed to sexual abuse,[20] CBT-TF for children exposed to physical abuse,[31] cognitive behavioural training children exposed to physical abuse,[32] and dyadic music therapy for children exposed to neglect[33] were not considered fully by the Evidence Review Group, as the small sample sizes in the study (<25) led the group to believe that the results could not be trusted.

b) Parenting Interventions, Clinic/Community

Recommendation

For children exposed to physical abuse, emotional abuse, and/or neglect (ages 2–12) and their caregivers, PCIT of at least 12 weeks in duration is recommended. This intervention has not been used with children exposed to sexual abuse and so it is not recommended for children with this exposure. (Conditional recommendation for the intervention; the body of evidence was rated as moderate certainty.)

On the basis of exposure to child maltreatment alone, there is insufficient evidence to recommend

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other clinic- or community-delivered parenting interventions, such as stress management, family network meetings with group work, and the Families Actively Improving Relationships (FAIR) Program. Note that this is a conditional recommendation against these interventions on the basis of exposure to maltreatment alone; however, the effectiveness of these interventions for specific symptoms (e.g., externalizing symptoms) or problems (e.g., substance use and addiction) is outside of the scope of this review. Providers should also consult relevant practice guidelines about other evidence-based interventions for specific symptoms and problems experienced by children. (Conditional recommendation against these interventions; the body of evidence was rated as very low certainty.)

Remarks

PCIT was originally developed to improve parenting skills and interactions between parents and children (ages three to seven) among families struggling with their children's behaviour problems (e.g., oppositional defiant disorder). PCIT has two sequential phases, the first focused on child-directed interaction and the second on parent-directed interaction. PCIT teaches parents communication skills via didactic presentations to parents and coaching of parents while they are interacting with their children. Parental coaching typically involves PCIT therapists' observing through a one-way mirror into the playroom and using a "bug-in-the-ear" system to communicate with parents as they play with their child. Like the counselling/therapy interventions discussed above, other clinic- and community-oriented parenting interventions differ in intensity/duration and focus (parent-focused vs. coaching parent-child interactions).

The costs of clinic- or community-delivered parenting interventions are likely moderate and depend on who is providing the service and where the service is provided, although the certainty of this cost is very low or non-existent (there are no studies about the costs of FAIR, for example). Cost effectiveness probably favours providing PCIT. For all other clinic- or community-delivered parenting interventions, cost versus benefits probably does not favour their provision. Equity is probably reduced though, since specific parenting interventions for child maltreatment are not widely available and would likely accrue costs to patients.

Clinic/community parenting interventions, including PCIT, are likely acceptable to clients and providers, with the exception of FAIR, which was deemed to be likely unacceptable to managers given that elements of the program are available 24/7. Parenting interventions were deemed to be likely feasible in the Canadian context.

Summary of the evidence

To determine the evidence for PCIT, three RCTs[34–36] were pooled. Two focused on children (average age of five) exposed to maltreatment (multi-abuse)[34,35] and one focused on children (2.5–12 years) exposed to physical abuse and neglect.[36] We have moderate certainty that at post-treatment, PCIT results in a small reduction in internalizing and externalizing symptoms, as well as low certainty that PCIT leads to a large increase in positive caregiver-child interaction (e.g., use of praise) and moderate to large decreases in negative caregiver-child interactions (e.g., use of commands).

RCTs for other evaluations show limited but promising or inconclusive results. For example, at post-treatment, stress management may result in small benefits in positive caregiver-child interaction (e.g., praise)[37] and FAIR may lead to large reductions in externalizing symptoms.[38]

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Family network meetings with group work show no significant benefit for important outcomes.[39]

c) Parenting Interventions, Home-Based

Recommendation

We cannot recommend for or against SafeCare[40] for children exposed to maltreatment at this time. (Cannot recommend for or against this intervention; the body of evidence was rated as moderate certainty.)

On the basis of exposure to child maltreatment alone, there is insufficient evidence to recommend intensive home-based parenting interventions for children exposed to maltreatment at this time, including attachment-oriented home visits,[41] promoting first relationships,[42] psychoeducation home visits,[23] multisystemic therapy,[43,44] Attachment and Biobehavioural Catch-up,[45] home visits by public health nurses,[46] Project Support,[47] and Internet-based Interacting Together Everyday, Recovery After Childhood TBI (InTERACT).[48] Note that this is a conditional recommendation against these interventions on the basis of exposure to maltreatment alone; however, the effectiveness of these interventions for specific symptoms (e.g., externalizing symptoms) or problems (e.g., substance use and addiction) is outside of the scope of this review. Providers should also consult relevant practice guidelines about other evidence-based interventions for specific symptoms and problems experienced by children. (Conditional recommendation against these interventions; the body of evidence was rated as very low certainty.)

Remarks

Parenting interventions delivered as intensive home-based services (typically referred to as home visiting services) vary drastically in intensity and duration. They usually involve a minimum of eight weekly sessions of 60 minutes or longer and up to or over a year of weekly visits. Sessions vary in focus and may involve didactic presentation of information about parenting skills, parent-child interaction, or strategies to cope with a child's behavioural problems, as well as referrals to community resources.

Unlike the other parenting or counselling/therapy interventions—given the intensity and duration of many intensive home-based parenting services—the costs of intensive home-based parenting interventions were determined to be large, although this is very uncertain or unknown (for example, there are no studies that describe or evaluate the costs of Project Support or InTERACT). Cost effectiveness probably does not favour providing intensive home-based parenting services to children exposed to maltreatment. Unlike the other parenting and counselling/therapy interventions, intensive home-based parenting interventions likely increase equity, as providers travel to caregivers' homes (or deliver the content online to caregivers' homes) and decrease the burden caregivers face in accessing services. These services are also more often directed at families with lower socioeconomic status and are generally found to have more engagement from clients. Intensive home-based parenting services are likely acceptable to clients and providers, although many components need to be in place for the intervention to be acceptable (e.g., training and support for providers travelling to homes). Intensive home-based parenting services are likely feasible to implement in Canada, with one exception of rural communities, given that providers would need to travel long distances to visit families.

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Summary of the evidence

Single RCTs have evaluated a range of intensive home-based parenting services, with some interventions showing promise. For example, at a six-year follow-up, we have moderate certainty that SafeCare for preschool-aged children exposed to maltreatment may enable small reductions in maltreatment recurrence.[40] We have very low certainty in a range of other intensive home-based parenting services, though. For example, we have very low certainty that at post-treatment attachment-oriented home visits (vs. standard care) for children (ages one to six) exposed to maltreatment may enable a small reduction in internalizing symptoms and an increase in maternal sensitivity (although the control group showed a greater reduction in externalizing symptoms).[41] We have very low certainty that promoting first relationships (vs. early educational support) for children (ages 10–24 months) exposed to maltreatment may enable an increase in caregiver sensitivity (but having no effect on the supportiveness of parent-child interactions).[42] We have very low certainty that multisystemic therapy (vs. parental training) for children (average age of 7–10 years) exposed to maltreatment may enable a small increase in positive parental behaviours (e.g., parental effectiveness) and small decrease in negative parent behaviours (e.g., parental unresponsiveness)[43] and that multisystemic therapy (vs. enhanced outpatient treatment) for children (ages 10–17) exposed to physical abuse may enable small benefits for reducing internalizing, externalizing and PTSD symptoms (but not depression or anxiety).[44] We have very low certainty that at five-year follow-up, Attachment and Biobehavioural Catch-up (vs. child development education) for children (average age of four to six years) exposed to maltreatment may result in small benefits to maternal sensitivity (but the control group showed greater reductions in externalizing symptoms).[45] Finally, we have very low certainty that Project Support may lead to small reductions in recurrence for children (ages three to eight) exposed to physical abuse and neglect.[47]

RCTs exploring psychoeducational parenting interventions[49] and psychoeducational home visits[23] showed no benefit to important outcomes and an RCT evaluating home visiting by public health nurses showed inconclusive benefits for children exposed to physical abuse and neglect.[46] One RCT evaluating an Internet-delivered home-based parenting intervention (InTERACT) was not considered fully by the Evidence Review Group, given that the small sample size in the study (<25) led the group to believe that the results could not be trusted.[48]

d) Child-Focused Skills Development

Recommendation

On the basis of exposure to child maltreatment alone, child-focused skills development is not recommended for children exposed to maltreatment at this time. Note that this is a conditional recommendation against this intervention on the basis of exposure to maltreatment alone; however, the effectiveness of this intervention for specific symptoms (e.g., depression) or problems (e.g., substance use and addiction) is outside of the scope of this review. Providers should also consult relevant practice guidelines about other evidence-based interventions for specific symptoms and problems experienced by children. (Conditional recommendation against intervention; the body of evidence was rated as very low certainty.)

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Remarks

Child-focused skills development includes interventions that address children's skills, such as social competencies. Resilient peer treatment is an example of a child-focused skills development intervention that seeks to improve preschoolers' social competencies via classroom play mediated by a resourceful peer.

The costs of child-focused skills development were deemed to be negligible where classroom settings are already in place, although the certainty of this is very low. Cost effectiveness favours providing child-focused skills development; this intervention is also likely acceptable (to clients and providers) and feasible to implement.

Summary of the evidence

Two RCTs[50,51] evaluated resilient peer treatment, although the results of these RCTs could not be pooled as different outcomes were explored across each RCT. Thus, at post-treatment we have very low certainty that resilient peer treatment (vs. controls) for children (ages three to five) exposed to physical abuse and neglect may enable a large reduction in anxiety/psychological problems, internalizing symptoms, and externalizing symptoms. However, the results of these RCTs are promising.

e) Other Evidence-Based Interventions

Recommendation

Following assessment by a qualified provider, children exposed to maltreatment may need to be referred to evidence-based treatments for specific symptoms or conditions (e.g., depression) or other concerns (e.g., substance use). At this time, there is insufficient evidence to refer children exposed to maltreatment to any other interventions simply based on this exposure; referrals to interventions should be based on an individual needs assessment. Mental health care, in accordance with WHO mhGAP[12] intervention guidelines and/or national or profession-specific evidence-based practice guidelines, should be delivered by professionals with a good understanding of child maltreatment and its consequences.

For further information

Please refer to VEGA's online education resources about child maltreatment, including the Recognizing and Responding Safely to Child Maltreatment Module and the Handbook Section on Child Maltreatment (https://vegaproject.mcmaster.ca/).

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