Appendix D Table 7. Characteristic of Randomized, Controlled Trials Included in the Sensitivity Analysis for Child Maltreatment Prevention Benefits and Harms (KQs 1 and 2)

| Author, Year(Program/Trial Name) | Co-Intervention | Group 1 (G1) Intervention Name, N  | Group 1 Intended Intervention | Group 1 Actual Intervention Received | Group 2 (G2) Intervention Name, N  | Group 2 Intended Intervention | Group 2 Actual Intervention Received |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Barth, 1991134(Child Parent Enrichment Program) | NR | Control, n=94 pregnant women | Referral to social and health services | Control group received referrals to social and health services indicated by a 2-hour assessment interview. In a few cases, a second interview was needed to complete the assessment and referral process. When families assigned to G2 refused services or accepted fewer than 5 visits (there were only 6 such families, and their mean number of visits was 2.1), they were reassigned to the control group. | Intervention, n=97 pregnant women | Intervention was provided by lay person paraprofessionals known as parenting consultants who were recruited to represent ethnic and geographic communities in the service region. They participated in a 9-week training course (over 100 hours). Assignment of a parenting consultant to a client was based on ethnic or geographic considerations. Home visits using task-centered approach to reduce the risk of parenting problems. Tasks included those done by the parenting consultant alone (e.g., providing transportation, advocating on client’s behalf), the client alone (e.g., attending prenatal care, eating two good meals per day), or conjointly (e.g., driving together to pick up food). | Average: 11 visits (range: 5–20). Parenting consultant and client completed an average of 17 tasks per case.  |
| DePanfilis and Dubowitz, 2005172(Family Connections) | The intervention (Family Connections) is provided to all arms, for different durations and with or without an added group element | Family connections for 3 months, n=62 families\* | Community-based service program that works with families in their homes and in the context of their neighborhoods; core components included emergency assistance (e.g., when eviction notice received), home-based family intervention (family assessment, outcome-driven service plans, individual and family counseling), service coordination with referrals targeted toward risk (e.g., substance abuse treatment) and protective factors (e.g., mentoring program), and multifamily supportive recreational activities (e.g., dinner gatherings, museum trips); direct services were expected to be provided for a minimum of 1 hr/week | Most families received a minimum of 1 hr/week of direct services; 59 of 62(95%) families completed the intervention; families received an average of 17 hours of total direct services (average 1.4 hr/week) | Family connections for 3 mo. enhanced with group intervention (FC3+g), n=NR | Not described/presented in article due to poor compliance | Only 32% of caregivers assigned to a group intervention attended any session, and very few graduated from the full group program |
| Dubowitz et al, 2009148(SEEK Model) | NR | Control, n=323 caregivers | Residents in the control group did not receive the training, did not use the PSQ, and provided standard pediatric care and an on-site human services worker with similar responsibilities as the social worker for the intervention group.  |  NR | Intervention, n=406 caregivers | SEEK Model care consisted of:1) specially trained residents who were trained over 2 half-days to address targeted risk factors for maltreatment such as maternal depression, substance use, etc., and to understand the relevance of these problems to children’s health; booster trainings were conducted every 6 months; 2) pocket cards were available for doctors containing salient information and a handbook of local resources and user-friendly parent handouts3) administration of the PSQ4) a social worker who worked closely with residents and families if the residents/families chose to involve them. Management often involved guidance and support in the clinic and referrals to community agencies. | NR |
| Dubowitz et al, 2012147(SEEK Model) | NA | Standard care, n=524 families | Standard care  | Health professionals at pediatric practices in the control group received no special training and provided standard pediatric primary care. Control practices did not receive SEEK materials or social work support. | A SEEK group, n=595 families | The SEEK model of enhanced pediatric primary care, delivered by health professionals in pediatric practices, is intended to identify and help address the impact of parental depression, substance abuse, major stress, and intimate partner violence on children’s health, development, and safety; how to briefly identify problems; and how to address them.  | Health professionals in SEEK pediatric practices attended 4-hour, small group training conducted by pediatricians, a social worker, and a psychologist. Trainings emphasized the use of a PSQ, a 20-item self-report questionnaire screening for targeted problems administered during the child’s checkup. Parents are given handouts for each problem and customized local agency listings. A social worker was available at each SEEK practice 1 day per week and by phone for health professionals and parents. The social worker provided crisis intervention and facility referrals.  |
| Duggan et al, 1999145 Duggan et al, 2004146(Hawaii Healthy Start Program) | NR | Control, n=290 families randomized, 270 families analyzed  | Provided with information and referral to other appropriate services in the community | NR | HSP, n=395 families randomized, 373 families included  | Home visits for 3–5 years by trained paraprofessionals to provide assistance, education, and services; model effective parent-child interaction; ensure child has medical home. Participants progress through stepped levels of care, decreasing in intensity as families achieve milestones in healthy functioning as followed: Level 1: visited weekly; Level 2: biweekly; Level 3: monthly; Level 4: quarterly, with explicit criteria for promotion; intervention was for 1, 2, or 3 years. | HSP home visitors delivered service to 373 families, among them 184 families were considered active by their respective program sites. Home visitors developed individual service plans for 71% of families, screened 55% of the index children, and assed parent-child interactions in 47% of all referred families. In the infant’s first year, all families: Mean number of visits during the infant’s first year: 1312 or more visits during the first year: 45%Frequency of visits:At least weekly: 1%Every 8–14 days: 28%Every 15–21 days: 22%Every 22–31 days: 11%Less than monthly: 25%No visits: 12% |
| Gray et al, 1977136Gray et al, 1979135 | One home visit when the child was between the ages of 17 and 35 months (mean: 26.8 months): mother interviewed; medical and social information involving the entire family collected; mother-child interaction observed; Denver Developmental Screening Test administered to child  | HRN group, n=25 families | All families received standard pediatric care.  | Investigators did nothing directly for the participating high-risk families assigned to the HRN group after discharge. However, all the available information was routinely shared with attending hospital staff, community agencies such as visiting nurse services, and the family physician or clinic.  | HRI group, n=25 families | Provision of pediatric care by one pediatrician at the Medical Center where the child is born.  | Special well-child care for high-risk families included promotion of maternal attachment to the newborn; contact with the mother by telephone on the second day after discharge; provision of more frequent office visits; giving more attention to the mother; |
| Hardy and Streett, 1989173(Child and Youth Program) | NA | Control, n=147 infants | NR | NR | Home visits, n=143 infants | Home visiting services, entirely delivered by a single home visitor (a college-educated, former resident of the community), starting when the child was 7–10 days old and provided routinely at 2–3 weeks before C&Y visits (which occurs at child age 2, 4, 6, 9, 12, 15, 18, 21, and 24 months old). Additional visits were made at the discretion of staff members. The home visitor was also available to families by telephone. The program was an extension of the pediatric primary care services provided in the clinics of a Federally funded (MCHB) Children and Youth Program. | Routine visits lasted 40–60 minutes. |
| Infante-Rivard et al, 1989174 | NR | Control group, n=26 mother-child dyad | Single postnatal visit at 2 to 4 weeks after birth by experienced public health nurses per a routine procedure.  | NR | Experimental group, n=21 mother-child dyad | Participants receive tree prenatal visits at 28, 30, and 36 weeks of gestation, and five postnatal visits at 1, 2, 5, 12, and 30 weeks. Content involves teaching and counseling.  | NR |
| Koniak-Griffin et al, 2002175Koniak-Griffin et al, 2003171(Early Intervention Program) | NA | Control, n=45 mothers | Traditional public health nursing care: one prenatal home visit made shortly after the participant’s entry into the study, and a second during the third trimester (visits focused on assessment and counseling related to prenatal health care, self-care, preparation for childbirth, education planning, and well-baby care [including immunizations]); additional home visit within 6 weeks postpartum to provide general information about child care, postpartum recovery, maternal and infant nutrition, home safety, community resources, and family planning | Mean (SD) number of home visits actually made171Prenatal period: 1.02 (0.26)Postpartum period: 1.09 (0.42) | Early intervention, n=56 mothers | Care by public health nurses using a case management approach with one nurse providing continuous care from pregnancy through 1 year postpartum: 4 “preparation for motherhood” classes, counseling, and a maximum of 17 1.5- to 2-hour home visits (2 prenatal and 15 postpartum)  | Mean number of home visits, intervention vs. control:171 2.13 (prenatal) and 10.35 (postpartum) vs. 1.02 (prenatal) and 1.09 (postpartum) |
| Mejdoubi et al, 2015176(The VoorZorg Study) | NR | Usual care, n=223 mothers | During pregnancy, women visited a midwife an average of 4 times for health education and physical exams. After birth, Youth Health Care nurses visited parent and baby week 1 (between 4–7 days) and week 2 after birth. In total, 9–11 check-ups are performed until the child’s second birthday. Consults were available and proceeded less frequently until the child’s 19th birthday. | NR | VoorZorg and usual care, n=237 mothers | In addition to usual care (see column N), trained and experienced VoorZorg nurses provided 10 home visits during pregnancy, 20 during the first, and 20 during the second year of life of the child. Each visit was between 1 hour and 1.5 hour. The purpose of the visits was effecting structured behavioral changes, conducting health education, discussing questions of expectant mother, setting and maintaining realistic achievable goals, increasing the mother’s self-efficacy, and involving the mother’s social network.  | On average, VoorZorg participants were included at 20 weeks of pregnancy and received an average of nine home visits during pregnancy. The average number of visitations after birth was not reported. VoorZorg nurses also communicated with participants via text message, telephone, and social media.  |
| Norr et al, 2003177(REACH-Futures) | NR | Standard care, n=219 families | Standard routine well-child visits at the clinic or provider of their choice | NR | REACH-F (Home visits by nurse-health advocate team), n=258 families | Community workers contact/conduct home visits with families within 2 weeks after initial discharge (following birth) monthly and more frequently if necessary. Nurse and community worker conduct home visits at 1, 6, and 12 months.  | Average client received around five home visits and seven contacts over the first 12 months.  |
| Paradis et al, 2013178(Building Healthy Children) | NR | Control, 227 families | Families randomized to the control group are screened and referred to clinic staff to receive community referrals and other support based on identified need. |   | Treatment group, n=270 families | Three evidence-based services (PAT, CPP, interpersonal psychotherapy) were delivered via home visits. Outreach nurses also assisted with concrete needs such as transportation to medical visits. EMR communications and intervention social workers ensured full integration with the medical home. | Mothers who screen positively for depressive symptoms are engaged into interpersonal depression treatment as soon as possible. Once depressive symptoms improve, families are transitioned into PAT or CPP services. |
| Wagner and Clayton, 1999179(Salinas Valley PAT) | NR | Control, n=199 families | Evaluation team periodically sent toys to the control group as a method of tracking their location and encouraging participation in the assessment. If annual assessments for the study revealed significant developmental delays or other problems, families were referred to appropriate services. |  NR | PAT, n=298 families | Offered monthly home visits for as long as the families chose to remain in the program, up to the child’s third birthday. Home visits were conducted by a trained parent educator and covered lessons from the national PAT curriculum. Parent educators modeled appropriate ways of interacting with the children, left supplemental materials for parents to read, and conducted periodic screenings of child’s hearing, vision, and general development and made referrals as appropriate. Voluntary group meetings were offered periodically during which parents discussed issues and received social support from other parents and parent educators. | Received an average of 20 visits over 3 years. Visits were planned to last 45–60 minutes but actually lasted 28–50 minutes. Only 15% of participant group families attended any group meeting. |
| Wagner and Clayton, 1999179(Teen PAT) | NR | Control, n=178 mothers | Evaluation team periodically sent toys to the control group as a method of tracking their location and encouraging participation in the assessment. If annual assessments for the study revealed significant developmental delays or other problems, families were referred to appropriate services. | Only services received were those the participants sought on their own from existing community health and human services providers, except the toys sent and annual assessments with referrals to appropriate services | Teen PAT program services alone, n=177 mothers | Offered monthly home visits and PAT group meetings through the children’s second birthdays. On average, participants received 10 visits during the 2 -year period. Trained parent educators covered lessons from the national PAT curriculum.  | Received an average of 10 visits over 2 years. Visits were planned to last 45–60 minutes but actual length was not measured. Group meeting attendance was low (average two meetings for G2 families). Also received an average of six additional telephone contacts. |

\*154 families originally randomized. Only 125 families had data at all three timepoints.

**Abbreviations:** CPP=child-parent psychotherapy; C&Y=children and youth; EMR=electronic medical record; FC=Family Connections program; G=group; HRI=high-risk intervention; HRN=high-risk nonintervention; HSP=Healthy Start Home visitation program; KQ=key question; MCBH=Maternal and Child Health Bureau; N/n=sample size; NA=not applicable; NR=not reported; PAT=Parents as Teachers; PSQ=Parent Screening Questionnaire; REACH=Resources, Education and Care in the Home; SD=standard deviation; SEEK=Safe Environment for Every Kid.