Evidence to Action Note
February 2023

Family and Community Services Insights, Analysis and Research (FACSIAR)

Which programs reduce maltreatment and improve safety for vulnerable children?

Snapshot

- This rapid evidence review identifies evidence-informed programs that help to reduce harm and maltreatment and improve outcomes for vulnerable children aged 0-5 years. Only systematic reviews, meta-analyses, or studies that used a randomised control trial or quasi-experimental design were included.
- Of the 34 programs that were rated according to evidence of their effectiveness, 25 programs were found to contribute to reducing maltreatment and improving safety for vulnerable young children.
- The majority of programs (22) identified in the review are designed to improve parenting competency and family functioning. Eighteen programs aim to prevent neglect and abuse, and reduce the incidence of contact with child protection services. A number of programs (14) target harsh and/or dysfunctional discipline and punishment. A small number of programs specifically address child health, child safety and domestic violence.
- The review identified common core components of these effective programs, including: engagement, building supportive relationships and social networks, building parental capacity and case management.
- The review highlights a need for more high quality research examining the effectiveness of Australian programs and the implementation of international programs in diverse Australian contexts, particularly with Aboriginal and culturally and linguistically diverse families.

Introduction

Child harm and maltreatment can have profound impacts on children's wellbeing and physical, psychological, emotional, behavioural and social development. These impacts can extend into adulthood and lead to poorer outcomes in economic opportunity, educational attainment, housing security, community participation, empowerment and health.

A variety of programs have been designed to help reduce child harm and maltreatment.

In 2021, the Department of Communities and Justice (DCJ) commissioned Western Sydney University to complete a rapid review to identify evidence from international and Australian research about programs that reduce harm and maltreatment and improve outcomes for vulnerable young children.

The review report, A rapid evidence review of early childhood programs to reduce harm and maltreatment and improve school readiness, was recently published. **This Evidence to Action note outlines the key findings from the child harm and maltreatment review.** Detailed descriptions about each program and how the core components are applied are available in the full report and on DCJ's early intervention Evidence Portal.

Why is reducing child harm important?

Child harm is any significant detrimental effect on a child's physical, psychological or emotional well-being. Child maltreatment is any non-accidental behaviour directed at children which is outside accepted norms of conduct and poses a significant risk of causing physical and/or emotional harm.[1] Child harm and maltreatment are associated with adverse outcomes in childhood and later life. Children who are subjected to neglect or abuse are more likely to experience physical injuries, growth delays,[2] learning difficulties and cognitive delays,[3, 4, 5] low self-esteem and difficulty forming relationships with peers,[6] and mental health issues such as anxiety, depression, withdrawal and post-traumatic stress disorder.[7 8] They are also more likely to engage in crime, delinquency,[9, 10, 11, 12] substance abuse,[13] self-harm[14] and suicidal ideation.[15] Experiences of harm and maltreatment in childhood can affect outcomes later in life, such as economic opportunity, educational attainment, housing security, community participation, empowerment and health.[16]

It is vital that children are able to grow and develop in safe, supportive families where they can experience psychological, emotional, behavioural and social wellbeing. Multidimensional support, including programs that help parents to develop positive parenting skills and address the underlying causes of negative parenting practices, is an important resource for vulnerable families and children.[17] The NSW Government is committed to investing in and delivering early intervention for children and families. One priority group is vulnerable young children aged 0-5 years with identified risk factors related to their parents and their first year of life, or significant involvement in the child protection system. Various programs have been designed to support this group. DCJ is building an evidence base about effective programs and their components, to inform service planning and delivery, and ensure that vulnerable groups can access services that work.

What did the rapid evidence review find?

The rapid evidence review was guided by the question: 'Which programs reduce harm and maltreatment for vulnerable children aged zero to five years?' The review was carried out following the technical specifications for the conduct of reviews for DCJ's early intervention Evidence Portal. The technical specifications ensure a rigorous and consistent approach to the assessment of program effectiveness.[18] Only systematic reviews, meta-analyses, or studies that used a randomised control trial or quasi-experimental design were included.

The search strategy returned 15,981 publications. The publications were screened to ensure that they fell within scope and were directly relevant to the guiding research question. A risk of bias assessment was then carried out and only studies found to have a low to moderate risk of bias were

included. Following all exclusions, 45 studies were included in the review. These 45 studies described **34 different child harm reduction programs**. The majority of studies and programs were from the US. **Of these 34 programs, 25 programs were identified as contributing to a reduction in harm and maltreatment for vulnerable young children.**

The review identified five different models of harm and maltreatment reduction

The review identified five different models of harm and maltreatment reduction among the 34 eligible programs. These models are not mutually exclusive – some programs align with two or more of the models. The five models are:

- home visiting programs
- programs mainly delivered in early childhood education settings
- therapeutic parent-child interaction programs
- programs delivered in clinical settings
- family therapy.

Parenting was the most common outcome domain identified

The review identified outcome domains and client outcomes to determine program effectiveness. A total of six outcome domains, with 66 unique client outcomes, were identified – see Table 1.

Table 1: Outcome domains

Outcome domain	Number of client outcomes	Number of programs targeting the outcome
Parenting	23	22
Child abuse and neglect	24	18
Discipline/punishment	9	14
Child health	5	5
Child safety	4	4
Domestic violence	1	2

The most common outcome domain was parenting, with 22 programs designed to reduce harsh, hostile and/or neglectful parenting, increase parenting competency and improve family functioning. The next most common outcome domains were child abuse and neglect with 18 programs, and discipline/punishment with 14 programs. The child abuse and neglect outcome domain encompassed programs that aim to prevent neglect and abuse, and reduce child abuse reports, contact with child protection services and out-of-home care placement. The discipline/punishment outcome domain covered programs that aim to reduce dysfunctional discipline strategies and attitudes, and prevent harsh and corporal punishment. A small number of programs had outcome domains relating to child health (5 programs), child safety (4) and domestic violence (2).

The review identified 25 programs which contributed to a reduction in harm and maltreatment for vulnerable young children

In order to understand which programs help to reduce harm and maltreatment in young children, the evidence for program effectiveness was rated for each of the 34 programs identified in the review using the DCJ evidence rating scale (see Appendix 1). The rating process involved three steps:

1. Rating the evidence for each program by outcome domain.
2. Rating the overall evidence for each program based on the outcome domain ratings.
3. Rating the overall direction of effect (positive, mixed, no effect or negative) for each program once overall program ratings were determined.

None of the programs achieved a 'well supported by research evidence' rating, which requires at least one high quality systematic review with meta-analyses based on randomised controlled trials to report statistically significant positive effects.

Of the 34 programs identified:

- Two programs (Parent-Child Interaction Therapy and Nurse-Family Partnership) were rated as 'supported' by research evidence, meaning that at least two high quality randomised controlled trials or quasi experimental design studies report statistically significant positive effects.
- A rating of 'promising' research evidence was given to 17 programs, meaning that at least one high quality randomised controlled trial or quasi experimental design study reports statistically significant positive effects.
- Six programs were rated as having 'mixed research evidence with no adverse effects'.
- Five programs were rated as having 'mixed research evidence with adverse effects'.
- The research evidence was rated as failing to demonstrate effect for four programs.

In total, the review identified 25 programs which contributed to a reduction in harm and maltreatment for vulnerable young children. Table 2 outlines all 34 programs identified in the review along with the outcomes they address and their evidence ratings.

Table 2: Evidence ratings of child harm and maltreatment reduction programs

Program	Outcomes	Evidence Rating
Nurse-Family Partnership	Child abuse and neglect Domestic violence Child safety Child health Discipline/punishment	Supported research evidence
Parent-Child Interaction Therapy	Discipline/punishment Parenting	Supported research evidence

Program	Outcomes	Evidence Rating
Australian Nurse-Family Partnership Program	Child abuse and neglect	Promising research evidence
The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits	Discipline/punishment	Promising research evidence
The Incredible Years Shortened Basic Version	Discipline/punishment Parenting	Promising research evidence
Chicago Parent Program	Discipline/punishment Parenting	Promising research evidence
Child-Adult Relationships Enhancement in Primary Care	Discipline/punishment Parenting	Promising research evidence
Group Attachment-Based Intervention	Parenting	Promising research evidence
HeadStart	Child abuse and neglect Parenting Discipline/punishment	Promising research evidence
Healthy Steps for Young Children Program	Parenting	Promising research evidence
Johns Hopkins Children and Youth Program	Child health Child abuse and neglect	Promising research evidence
ParentCorps	Parenting	Promising research evidence
Parents as Teachers	Child abuse and neglect	Promising research evidence
Pride in Parenting Program	Parenting	Promising research evidence
Right@Home	Parenting Child safety	Promising research evidence
SafeCare	Child abuse and neglect Parenting	Promising research evidence
SafeCare+	Child abuse and neglect Parenting Domestic violence	Promising research evidence

Program	Outcomes	Evidence Rating
Safe Environment for Every Kid	Child abuse and neglect Child health Discipline/punishment	Promising research evidence
Self-Directed Triple P	Discipline/punishment Parenting	Promising research evidence
Early Start	Child health Parenting Child abuse and neglect	Mixed research evidence (with no adverse effects)
Family Support Program	Child abuse and neglect	Mixed research evidence (with no adverse effects)
Parent Training Program	Parenting	Mixed research evidence (with no adverse effects)
Promoting First Relationships	Child abuse and neglect	Mixed research evidence (with no adverse effects)
Relief Nursery Program	Parenting Child abuse and neglect	Mixed research evidence (with no adverse effects)
SafeCare Dad to Kids (Dad2K)	Child abuse and neglect Discipline/punishment Parenting	Mixed research evidence (with no adverse effects)
Adults and Children Together against Violence / Parents Raising Safe Kids Program	Discipline/punishment Parenting	Mixed research evidence (with adverse effects)
Hamilton Nurse Home Visiting Program	Child abuse and neglect	Mixed research evidence (with adverse effects)
Healthy Families America Program	Child abuse and neglect	Mixed research evidence (with adverse effects)
Parents as Teachers + SafeCare at Home	Child safety Child abuse and neglect Child health Discipline/punishment	Mixed research evidence (with adverse effects)
Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline	Discipline/punishment Parenting	Mixed research evidence (with adverse effects)

Program	Outcomes	Evidence Rating
Video-Feedback to Promote Positive Parenting and Sensitive Discipline in Foster Care	Discipline/punishment Parenting	No effect
Together We Can	Discipline/punishment	No effect
Family Group Conferencing*	Child abuse and neglect	No effect
e-Parenting Program	Parenting Child abuse and neglect	No effect

* It should be noted that this finding is based on a randomised controlled trial conducted in the US (Hollinshead et al. 2017) and does not consider the implementation of Family Group Conferencing in Australia. Information on the effectiveness of Family Group Conferencing in the Australian context will be available shortly through the release of the NSW evaluation of Family Group Conferencing.

The review identified four core components of effective child harm and maltreatment reduction programs

In building evidence of how best to achieve positive outcomes for vulnerable groups, some NSW Government program areas are taking a 'core components' approach. The approach involves identifying treatment programs that have been found to be effective in rigorous studies, and distilling components that are common across them. The benefits of the approach include increased accessibility, translation and uptake of evidence to support evidence-informed decision-making.

The review applied a core components approach to programs that were found to demonstrate positive effects for specific outcomes. The programs were reviewed to identify broad categories or themes that group together specific activities. Following the technical specifications for the review, only those core components mentioned five or more times could be considered common across the evidence base. The review identified four core components and thirteen flexible activities in programs that contribute to a reduction in child harm and maltreatment. The four common **core components** are: **engagement, building supportive relationships and social networks, building parental capacity, and case management.**

What are core components and flexible activities?

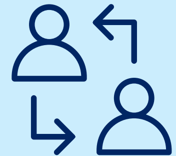
Core components are the fixed elements, features or functions of a program. Flexible activities are the variable aspects within core components, and may take on different forms according to local context. In other words, the flexible activities are the elements that operationalise the core components.

While it helps to identify common components of programs across the evidence base, the core components approach does not indicate which components are critical to program effectiveness, nor does it provide a measure of the acceptability of components with different groups. Many of the effective programs identified in the review had other components that may have been critical to their success in local contexts. Furthermore, the evidence of effectiveness relates to programs delivered in their entirety and does not indicate whether a new combination of components will be equally effective in achieving specific outcomes.

Engagement

The way that services engage with families is crucial to ensuring parents/carers participate in a program until they have achieved their goals. The most significant **flexible activities** that engage families are **sustained home visiting**, and **engaging and relevant delivery of curriculum material**. **Overcoming barriers** to engagement or attendance in a program increases the positive impact of the program. This can be done through providing **practical support for attendance**, and ensuring the program is flexible enough to be **tailored to the needs of the family**.

Practice example



Core component: Engagement.

Flexible activity: Home visiting, where a program is substantially delivered through the service provider visiting the family in their home.

Implementation: During home visits, the home visitor builds a relationship with the family, and curriculum content is delivered through activities and conversation. The number of visits varies by program, as does the time over which they occur, from 10 weeks to three years.

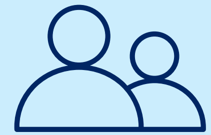
Target groups: First time mothers who are vulnerable, Aboriginal mothers, families at risk, families with prior contact with child protection services.

Programs that use this flexible activity: Nurse-Family Partnership, Australian Nurse-Family Partnership Program, Healthy Families America, Early Start, Right@Home, Parents as Teachers, Pride in Parenting, Healthy Steps for Young Children, Parents as Teachers + SafeCare at Home, SafeCare, SafeCare+, SafeCare Dad2K, Hamilton Nurse Home Visiting Program, Promoting First Relationships.

Building supportive relationships and social networks

Supportive relationships between parents/carers and their children are fundamental to reducing harm and maltreatment. The relationship between the service provider and the family is important to achieve this aim. Supportive relationships enable parents/carers to seek advice and respite from others when needed. **Flexible activities** are focused on relationship-building. The curriculum material of the program includes activities to **support parents to build supportive relationships with their children**, and interaction between parent and child is often **a focus of the delivery sessions**. The **relationship between parents and the service provider** is often built through **regular delivery sessions over a long-term timeframe**.

Practice example



Core component: Building supportive relationships and social networks.

Flexible activity: Building the parent-child relationship.

Implementation: The program uses curriculum material that aims to build parenting skills and nurture a positive relationship between parent and child. It facilitates activities between parent and child, such as playgroups that children and parents attend together, or video-recording parent-child interactions and giving coaching feedback to parents.

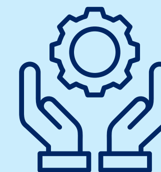
Target groups: First time mothers who are vulnerable, families at risk, families with prior contact with child protection services, multi-generational migrant families, low-income migrant families, foster families, families with a child showing signs of problems with socio-emotional or cognitive development, families with a child with behavioural concerns.

Programs that use this flexible activity: Healthy Families America, Parents as Teachers + SafeCare at Home, Promoting First Relationships, Relief Nursery Program, Parent-Child Interaction Therapy, Self-Directed Triple P, The Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline, Child-Adult Relationship Enhancements in Primary Care.

Building parental capacity

Parents/carers can be supported via parenting education, coaching and modelling sessions, focusing on topics such as child development and needs, child behaviour management strategies, and practical advice about routines. Sessions are also intended to develop parents' general living skills to increase their parental capacity and ability to manage other aspects of their lives. **Flexible activities** include a **standard curriculum of parenting skills**, **trained service providers**, and **life skills development**. Activities to improve parenting capacity are often delivered by service providers trained in a specific curriculum or program. Delivery is mainly via home visiting and parenting classes.

Practice example



Core component: Building parental capacity.

Flexible activity: Trained service providers.

Implementation: Service providers who deliver the program as home visitors, facilitators or clinicians are trained in the program and often have professional qualifications, skills, and experience. They sometimes also have relevant lived experience and cultural knowledge.

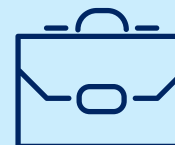
Target groups: First time mothers who are vulnerable, Aboriginal mothers, families at risk, families with prior contact with child protection services, families with a child showing signs of problems with socio-emotional or cognitive development, families with a child with behavioural concerns, parents lacking parenting skills, culturally diverse communities, mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child.

Programs that use this flexible activity: Nurse-Family Partnership, Australian Nurse-Family Partnership Program, Early Start, Right@Home, Pride in Parenting, Healthy Steps for Young Children, Parents as Teachers + SafeCare at Home, Promoting First Relationships, Johns Hopkins Child and Youth Program, Hamilton Nurse Home Visiting Program, HeadStart, Relief Nursery Program, Family Support Program, ParentCorps, Parent-Child Interaction Therapy, The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits, The Incredible Years Shortened Basic Version, Safe Environment for Every Kid, Child-Adult Relationship Enhancements in Primary Care, Group Attachment-Based Intervention, Adults and Children Together Against Violence.

Case management

Understanding and addressing the material, emotional and practical support needs of families is crucial to improving outcomes. Programs that aim to reduce harm for children specifically target at-risk families. Universal programs are often not appropriate given the complex needs that families have. Further referrals are often required. **Flexible activities** therefore include **appropriate referrals**, **targeted recruitment and screening**, and **integration with other services and onward referrals to other services and agencies**. These activities can be delivered with different levels of intensity and for short or long periods of time.

Practice example



Core component: Case management.

Flexible activity: Integration with other services and onward referrals.

Implementation: Programs achieve integration with other services in a variety of ways, including embedding the program in paediatric clinical practice, incorporating health visits in the program, and integrating parenting programs and support with childcare delivery at HeadStart centres.

Target groups: First time mothers who are vulnerable, Aboriginal mothers, families at risk, families with a child showing signs of problems with socio-emotional or cognitive development, parents lacking parenting skills, culturally diverse communities.

Programs that use this flexible activity: Nurse-Family Partnership, Healthy Families America, Healthy Steps for Young Children, Johns Hopkins Children and Youth Program, Hamilton Nurse Home Visiting Program, HeadStart, Relief Nursery Program, Family Support Program, ParentCorps, Safe Environment for Every Kid.

Limitations of the evidence

The evidence identified in this review has some limitations:

- The technical specifications for the review limited inclusion to programs that have been subject to a randomised controlled trial or a high quality quasi experimental design study, and excluded non-peer reviewed and grey literature. This means the findings only relate to programs that met the narrow scope for inclusion and had a very rigorous evidence base. The search strategy was also confined to specific age and vulnerability criteria, and excluded hand searching. Consequently, there may be additional studies addressing relevant programs and program outcomes that were not captured. It is important not to confuse a lack of evidence unearthed in the review with a lack of program effectiveness.
- Requiring such a high standard of evidence resulted in a positive bias towards US-based programs – 22 of the 34 programs reviewed relied exclusively on US-based studies, and only four programs included Australian studies. Consequently, the review included only two studies that directly reported on outcomes relevant to First Nations families (one with Aboriginal families and one with Maori families). The review is therefore limited by the paucity of Australian research, particularly as this relates to children who experience marginalisation and adversity, including Aboriginal children and children from culturally and linguistically diverse (CALD) backgrounds.

Where to from here?

The findings from the review allow us to assess current practice against evidence-informed models and build more of what works into program design and practice across services targeting vulnerable children. Some of the programs identified in the review are already being implemented in NSW by DCJ (e.g. SafeCare, Parent-Child Interaction Therapy and Family Group Conferencing), or in a broader early intervention setting (e.g. Australian Nurse-Family Partnership and Triple P). DCJ is applying evidence from the review to improve child and family support services.

In applying a core components approach, which seeks to overcome some of the implementation challenges posed by manualised programs, the review helps to build a common evidence-informed framework that DCJ and service providers can use to develop and implement flexible, tailored services.

The review highlights a need for more high quality Australian research examining the effectiveness of childhood interventions and the implementation of international programs in diverse Australian contexts, including specifically with Aboriginal and CALD families. It is vital that governments invest in rigorous evaluation of programs to build the body of evidence.

Implementation considerations

- whether the program has been manualised to help service providers deliver it with fidelity
- whether the program is flexible enough to be adapted to meet the needs of different groups without compromising program effectiveness
- characteristics of the target group/s that the program has been delivered effectively to
- the required skills and qualifications of the service provider
- how the program will work with other available services
- the purpose of implementing the program and how this aligns with current funding priorities
- program dosage.

The findings have implications for the selection and implementation of programs. While program ratings are one key consideration in deciding which programs to fund and deliver, the local context is also important. The best programs on offer should be implemented, however careful consideration should be given when adapting international programs to ensure that they are relevant to diverse Australian contexts. Programs should only be implemented after extensive consultation with practitioners and community members with cultural knowledge. Although the evidence base is currently limited, programs developed in the Australian context should be considered.

More information

More information can be found in the full report: Stout B, Goward P, Dadich A, Grace R, Perry N, Knight J, Townley C, Ng J & Mugadza T 2022, Evidence bank rapid review: A rapid evidence review of early childhood programs to reduce harm and maltreatment and improve school readiness, Western Sydney University, Penrith, NSW.

Detailed program descriptions are available on DCJ's early intervention Evidence Portal.

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Appendix 1: Evidence Rating Scale and Direction of Effect (NSW Department of Communities and Justice, 2021)

Rating	Direction of effect	Description
Well-supported by research evidence	Positive	• At least one high-quality* systematic review with meta-analyses based on randomised controlled trials reports statistically significant positive effects for at least one outcome • No studies show statistically significant adverse effects
Supported research evidence	Positive	• At least two high-quality randomised controlled trial and/or quasi-experimental design studies report statistically significant positive effects for at least one outcome, AND • Fewer randomised controlled trials of similar size and quality show no observed effects than show statistically significant positive effects for the same outcome(s), AND • No randomised controlled trials show statistically significant adverse effects
Promising research evidence	Positive	• At least one high-quality randomised controlled trial and/or quasi-experimental design study reports statistically significant positive effects for at least one outcome, AND • Fewer randomised controlled trials and/or quasi-experimental designs of similar size and quality show no observed effects than show statistically significant positive effects, AND • No randomised controlled trials and/or quasi-experimental designs show statistically significant adverse effects
Mixed research evidence (with no adverse effects)	Mixed	• At least one high-quality randomised controlled trial and/or quasi-experimental design reports statistically significant positive effects for at least one outcome, AND • An equal number or more randomised controlled trials and/or quasi-experimental designs of similar size and quality show no observed effects than show statistically significant positive effects, AND • No randomised controlled trials and/or quasi-experimental designs show statistically significant adverse effects

Rating	Direction of effect	Description
Mixed research evidence (with adverse effects)	Mixed	• At least one high-quality randomised controlled trial and/or quasi-experimental design reports statistically significant adverse effects for at least one outcome, AND • An equal number or more of randomised controlled trials and/or quasi-experimental designs show no observed effects than show statistically significant adverse effects, AND/OR • At least one high-quality randomised controlled trial and/or quasi-experimental design shows statistically significant positive effects for at least one outcome
Evidence fails to demonstrate effect	No effect	• At least one high-quality systematic review with meta-analyses based on randomised controlled trial and/or quasi-experimental design reports no observed effects for all reported outcomes, OR • At least one high-quality randomised controlled trial reports no observed effects for all reported outcomes • Criteria are not met for mixed research evidence (with or without adverse effects)
Evidence demonstrates adverse effects	Negative	• At least one high-quality systematic review with meta-analyses based on randomised controlled trial and/or quasi-experimental design reports statistically significant adverse effects for at least one outcome, OR • At least one high-quality randomised controlled trial and/or quasi-experimental design reports statistically significant adverse effects for at least one outcome, AND • Fewer randomised controlled trials and/or quasi-experimental designs show no observed effects, AND/OR • No randomised controlled trial and/or quasi-experimental design shows statistically significant positive effects

* High-quality indicates studies with low-to-moderate risk of bias.

Appendix 2: Characteristics of child harm reduction programs

Model	Program (Study used to rate the program)	Design		Risk of bias score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT[1]	QED[2]			Home visits	Group sessions	Other	<6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
Home visiting programs	**Early Start** (Fergusson et al. 2005) *A home visiting program designed in New Zealand, which assesses family needs, issues, challenges, strengths, and resources and develops a positive partnership between the family support worker and client.*	✓		6	391	✓						✓				✓	Mixed research evidence (with no adverse effects)
	e-Parenting Program (Ondersma et al. 2017) *A multi-component computerised supplement to be used in home visiting programs such as Healthy Families America.*	✓		5	413	✓				✓						✓	Evidence fails to demonstrate effect
	Hamilton Nurse Home Visiting Program (MacMillan et al., 2005) *A Canadian nurse home visiting program delivered to families who have been subject to a reported incidence of physical abuse or neglect.*	✓		4	163 F*	✓					✓					✓	Mixed research evidence (with adverse effects)
	Nurse-Family Partnership (Eckenrode et al., 2000) *A home visiting program for first-time mothers designed to address risk factors for child maltreatment.*	✓		5	324 M/I	✓					✓					✓	Supported research evidence
	Nurse-Family Partnership (Eckenrode et al., 2017)	✓		4	324 M/I	✓					✓					✓	Supported research evidence
	Nurse-Family Partnership (Olds et al. 1994)	✓		5	324 M/I	✓					✓					✓	Supported research evidence

[1] Randomised controlled trial.
[2] Quasi-experimental design study.

Model	Program (Study used to rate the program)	Design		Risk of bias score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT[1]	QED[2]			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
Home visiting programs	**Nurse-Family Partnership** (Olds et al. 1999)	✓		5	995 M/I	✓					✓					✓	Supported research evidence
	Australian Nurse-Family Partnership Program (Segal et al. 2018) *An Australian adaptation of the program based on Olds' model, designed to be culturally sensitive to the needs of Indigenous families.*		✓	7	854	✓			Not reported				Not reported				Promising research evidence
	Healthy Steps for Young Children (Minkovitz et al. 2007) *This model introduces a child development expert into the paediatric primary care practice for an integrated approach to child development.*	✓		5	3,165	✓	✓	✓				✓				✓	Promising research evidence
	Johns Hopkins Children and Youth Program (Hardy & Streett 1989) *A community-based home visiting service providing health and parenting education for inner city mothers and their infants.*	✓		5	263 M/I	✓					✓			✓			Promising research evidence
	Healthy Families America (Green et al. 2017) *A home visiting program designed to assist new parents with their parenting needs and personal issues, review the child's developmental progress, ensure safety in the home, and support successful adaptation to parenthood.*	✓		7	636	✓			✓				✓				Mixed research evidence (with adverse effects)
	Healthy Families America (DuMont et al., 2008)	✓		6	971	✓						✓				✓	Mixed research evidence (with adverse effects)

Model	Program (Study used to rate the program)	Design		Risk of bias score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT[1]	QED[2]			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
Home visiting programs	**Healthy Families America** (LeCroy and Lopez, 2020)	✓		5	165	✓				✓						✓	Mixed research evidence (with adverse effects)
	Healthy Families America (Rodriguez et al. 2010)	✓		6	522	✓						✓				✓	Mixed research evidence (with adverse effects)
	Right@Home (Goldfeld et al. 2019) *An Australian nurse home visiting program based on the maternal early childhood sustained home-visiting (MECSH) program.*	✓		7	596	✓					✓					✓	Promising research evidence
	Parents as Teachers (Jonson-Reid et al. 2018) *A home visiting program promoting optimal early development, learning and health of children by supporting and engaging their parents/caregivers.*	✓		5	122	✓					✓					✓	Promising research evidence
	Parents as Teachers + SafeCare at Home (PATSCH) (Guastaferro et al., 2018) *A combination of the SafeCare and Parents as Teachers programs. The goals of the program are to improve parent-child relationships, improve school readiness and reduce risk of maltreatment through pedagogical approaches and skills-based learning.*	✓		7	93 F	✓			✓				✓				Mixed research evidence (with adverse effects)
	Pride in Parenting (Katz et al., 2011) *A community-based program targeting African American mothers who have not accessed adequate prenatal care.*	✓		5	286	✓	✓			✓						✓	Promising research evidence

Model	Program (Study used to rate the program)	Design		Risk of bias score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT[1]	QED[2]			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
Home visiting programs	**Promoting First Relationships** (Oxford et al., 2016) *A relationship- and strengths-based home visiting service that aims to help families facing adversity to meet their children's social and emotional needs, including a sense of safety and security.*	✓		8	228	✓			✓				✓				Mixed research evidence (with no adverse effects)
	SafeCare (Gershater-Molko et al., 2002) *A structured training program for parents of children aged 0 to 5 years, reported for child abuse and/or neglect.*	✓		6	82 F	✓			✓				✓				Promising research evidence
	SafeCare (Whitaker et al., 2020)	✓		6	193 P	✓			✓				✓				Promising research evidence
	SafeCare Dad to Kids Program (Dad2K) (Self-Brown et al., 2017)	✓		4	99 FA	✓				✓			✓				Mixed research evidence (with no adverse effects)
	SafeCare+ (Silovsky, 2011)	✓		4	105 P	✓			Not reported				Not reported				Promising research evidence
Programs that gave centrality to early childhood education services	**Chicago Parent Program** (Gross et al., 2009) *A parenting program that builds on the strengths of the Webster-Stratton Incredible Years model. The goals of the program are to improve parent self-efficacy, discipline strategies, and parent behaviour during free play and clean-up sessions, and to reduce the frequency of child behaviour problems.*	✓		5	292 F		✓		✓				✓				Promising research evidence
	Family Support Program (Calheiros et al., 2017) *A program based on the Comprehensive Child Development Program, following the principles of cognitive and behavioural parenting programs based on social learning models.*	✓		5	36 F	✓	✓		✓							✓	Mixed research evidence (with no adverse effects)

Model	Program (Study used to rate the program)	Design		Risk of bias score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT[1]	QED[2]			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
Programs that gave centrality to early childhood education services	**HeadStart** (Green et al., 2020) *The largest publicly supported childcare program in the USA targeted at low-income children, and children with disabilities, two groups at high risk for maltreatment. The goals of the program are to improve parenting, reduce maltreatment including the use of abusive discipline or neglectful behaviours, and promote parental involvement and parent education.*	✓		5	2,794 M/I			✓				✓				✓	Promising research evidence
	HeadStart (Zhai et al. 2013)		✓	4	2,807 F			✓	Not reported				Not reported				Promising research evidence
	ParentCorps (Dawson-McClure et al., 2015) *A program utilising school personnel (mental health professionals and teachers) as the facilitators of a parenting program and a concurrent group for children.*	✓		6	1050 C		✓		✓				✓				Promising research evidence
Therapeutic parent-child interaction programs	**Relief Nursery Program** (Eddy et al., 2020) *Designed for and targeted at economically vulnerable families, with the aim of decreasing instances of child maltreatment.*	✓		5	180P 180C	✓	✓	✓				✓	Not reported				Mixed research evidence (with no adverse effects)
	Parent-Child Interaction Therapy (PCIT) (Leung et al., 2009) *An individualised, evidence-based treatment program for preschool children displaying disruptive, oppositional, and defiant behaviour.*		✓	4	110 P			✓	Not reported				✓				Supported research evidence
	Parent-Child Interaction Therapy (PCIT) (Thomas & Zimmer-Gembeck, 2012)	✓		6	152 M/I			✓	✓				✓				Supported research evidence
	Self-Directed Triple P (Markie-Dadds & Sanders, 2006) *A behavioural family program based on the Triple P program.*	✓		6	47 F			✓	✓				✓				Promising research evidence

Model	Program (Study used to rate the program)	Design		Risk of bias score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT[1]	QED[2]			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
Therapeutic parent-child interaction programs	**Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD)** (Negrão et al., 2014) *This program was developed in the Netherlands to address disruptive behaviour in very young children.*	✓		6	43	✓			✓							✓	Mixed research evidence (with adverse effects)
	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD) (Stolk et al., 2007)	✓		6	237 F	✓				✓						✓	Mixed research evidence (with adverse effects)
	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD) (Yagmur et al., 2014)	✓		7	76 M/I	✓			✓							✓	Mixed research evidence (with adverse effects)
	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline in Foster Care (VIPP-SD-FC) (Schoemaker et al., 2020)	✓		9	55 F	✓			✓							✓	Evidence fails to demonstrate effect
Programs delivered in clinical settings	**Adults and Children Together Against Violence: Parents Raising Safe Kids** (Portwood et al., 2011) *A universal approach to prevention, incorporating education aimed at parents and primary caregivers.*	✓		4	197			✓	✓				Not reported				Mixed research evidence (with adverse effects)
	Child-Adult Relationship Enhancement in Primary Care (PriCARE) (Schilling et al., 2017) *A trauma-informed group training program to teach caregivers techniques to support the social and emotional growth of children.*	✓		5	120 P		✓		✓				✓				Promising research evidence
	Group Attachment-Based Intervention (GABI) (Steele et al., 2019) *This program aims to improve the mother-child relationship and prevent abuse for mothers at risk of maltreating their children because of a heavy trauma burden, mental health challenges, or prior removal of a child.*	✓		5	78 P		✓		✓				✓				Promising research evidence

Model	Program (Study used to rate the program)	Design		Risk of bias score	Final Sample Size*	Mode			Duration				Dosage				Evidence rating
		RCT[1]	QED[2]			Home visits	Group sessions	Other	< 6months	6-12months	1-2 years	3+ years	Weekly	Fortnightly	Monthly	Varies with age of infant or family needs	
Programs delivered in clinical settings	**The Incredible Years Preschool BASIC Parenting Program Enhanced with Home Visits** (Karjalainen et al., 2019) *This is a series of group-based programs for parents of children at different ages, developed by Webster-Stratton and others in the USA. The programs included here are those for children aged between 2 and 8 years with disruptive behavioural problems.*	✓		8	98 P	✓	✓		✓				✓				Promising research evidence
Programs delivered in clinical settings	**The Incredible Years Shortened Basic Version** (Reedtz et al., 2011)	✓		7	189 P		✓		✓				✓				Promising research evidence
Programs delivered in clinical settings	**Parent Training Program** (Li et al., 2013) *A program that aims to improve the parent–child relationship and decrease parental stress by reducing harsh parenting at the time of school transition.*	✓		6	120 F		✓		✓				✓				Mixed research evidence (with no adverse effects)
Programs delivered in clinical settings	**Safe Environment for Every Kid (SEEK)** (Dubowitz et al. 2009) *A face-to-face program delivered as clinic care in a paediatric clinic.*	✓		4	558 F			✓			✓		✓				Promising research evidence
Family Therapy	**Family Group Conferencing** (Hollinshead et al., 2017) *A family-centered practice intended to elevate the voice and the role of participants in the decision-making process and address the power differential between agency staff and families inherent in child welfare practice.*	✓		8	503 F			✓	Not reported				Not reported				Evidence fails to demonstrate effect
Family Therapy	**Together We Can** (Adler-Baeder et al., 2018) *This is a relationship and marriage education program that aims to develop relationship skills for adults in couple and co-parenting relationships and thus reduce harm in the family.*		✓	5	154 P		✓		✓				✓				Evidence fails to demonstrate effect

* Code: M/I: mothers and infants; F: families; C: children; P: parents; FA: fathers

Endnotes

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02-2023_WSU Child harm reduction_E2A_24-02-23