Supporting the Roadmap for Reform: Evidence-informed practice

The Centre for Community Child Health

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This report was prepared by the Centre for Community Child Health on behalf of the Department of Health and Human Services. Its purpose is to build the capability and effectiveness of the workforce to ensure the ongoing safety and wellbeing of children across Victoria.

Note. In keeping with DHHS practice, where the term 'Aboriginal' is used, it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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Executive summary

This report was commissioned as part of the Department of Health and Human Services (DHHS)'s *Roadmap for Reform*, a systematic approach to improving the Victorian child and family system, incorporating the statutory child protection system, out-of-home care, and early intervention and prevention services for children and families experiencing vulnerabilities. The purpose of this project was to prepare a 'menu' of evidenced-based practices and programs relevant to six key areas, corresponding to a tiered continuum of services:

- families who function well
- families who have some difficulties
- families at risk of child maltreatment
- families receiving statutory child protection services
- children living in out-of-home care
- care leavers.

The project also aimed to provide a set of recommendations to support the implementation of the menu in Victoria.

The report begins with a consideration of evidence-based practice as it is often understood. This reveals that the common practice of equating evidence-based practice with evidence-based programs or treatments does not capture its true multidimensional nature. Properly understood, *evidence-informed practice* involves three key components: *evidence-based programs*, *evidence-based processes*, and *client and professional values and beliefs.*

- *Evidence-based programs* refer to interventions or programs that have been shown through rigorous formal testing to be effective in building client competencies and changing behaviour and functioning.
- *Evidence-based processes* refer to the way in which service providers and the service system as a whole engage and work with families, individually and collectively.
- *Client and professional values and beliefs* refer to the crucial role played by values and beliefs in determining what goals are important, what interventions and programs are acceptable, and how effective these are.

The evidence regarding each of these key components was reviewed.

Because of the limited time available, the review of *evidence-based programs* utilised a rapid evidence assessment methodology that identified more than 190 potentially relevant programs. Those with the strongest research evidence were considered 'best-practice' and selected for inclusion in the menu. The final list includes a total of 33 programs that had been proven to be effective in reducing child maltreatment rates or ameliorating the effects of maltreatment. The majority of these focus on families who are either at serious risk of child maltreatment, are receiving statutory child protection services, or have children in out of home care. This reflects a general focus on treatment rather than prevention or very early intervention. Similarly, only a few programs were identified at the other end of the spectrum, demonstrating effective interventions for the transition to independent living. Full details of each of the programs are provided in an appendix to the report, along with a table providing an overview of the programs. The menu includes information on the key differences between practices, the outcomes that can be achieved through the practices, the relative effectiveness

of the practices, and the extent of capacity or capability gaps that would need to be addressed before the practices could be implemented in Victoria.

The review of *evidence-based* processes looked at convergent sources of evidence and found that they all pointed to the same overall conclusions: *how* services are delivered is as important as *what* is delivered, and the quality of the relationships between practitioners and parents are central to achieving the objectives of services. When working with families facing multiple challenges, successful and sustained engagement with families is the precondition for delivering programs that build parental competencies and create change. However, engagement in itself does not lead to significant change or improved outcomes, but constitutes a necessary but not sufficient condition for change: the practitioner-family relationship is the medium through which evidence-based programs can be delivered. Thus, practitioners should be considered not only as *providers* of treatment, but also as a *means* of treatment.

The review of the evidence regarding the third key component, the *values and beliefs of clients and professionals,* found that, for services to be effective, they must not only use evidence-based processes and evidence-based programs, but must also reflect the values of clients and the outcomes that are important to them. Overall, the evidence indicates that parental and professional values and beliefs play an important role in determining whether interventions are acceptable to clients, and therefore whether the interventions are likely to be implemented. Regardless of their strength of evidence, programs are unlikely to be effective if the clients do not see them as addressing their most pressing concerns, or that do so in ways that are inconsistent with family values, or that are not easily implementable in their particular circumstances.

Overall, the evidence regarding the three elements indicates that all three make important contributions to achieving positive outcomes. The overall process (called *evidence-informed practice* to distinguish it from the common usage of evidence-based practice) should be understood as a decision-making process, a way of blending the three major sources of 'evidence' in practice. An *evidence-informed decision-making* model for combining the various sources of evidence in service delivery is outlined. This nine-step process begins with engagement and tuning into family values and priorities, rather than with professionals deciding beforehand what the family needs and what strategies are most appropriate for meeting those needs. Evidence-based programs and strategies have an important role to play, but always in the context of family values and priorities. Information about such programs is not introduced until a partnership has been established and the professional has understood the family values and circumstances.

The next section of the report explores how a model of evidence-informed practice can be implemented at the six different levels of service. The following were among the points made in this wide-ranging review.

- The importance of addressing the conditions under which families are raising young children, Action at this level goes well beyond what a single government department such as DHHS can do, and necessarily involves multiple sectors and levels of government, as well as non-government services.
- The importance of basing support to families on a strong universal service platform, and of strengthening the capacity of universal services to meet the basic needs of all children and families, regardless of needs, abilities and background.
- The importance of identifying and responding to the 'background' factors that compromise parenting and family functioning.

- The challenge of building a service system based on the principle of progressive universalism, which is an approach based upon a strong universal service base that adds levels of support progressively for those with additional needs.
- The core role played by parent-professional relationships in working with families involved in the child protection system.
- The importance of providing support to carers and residential workers as well as the young people themselves who are in out-of-home care.
- The lack of evidence-based programs for care leavers and the need to trial promising programs.

Next, the report explores the implications for training and supervision, looking specifically at the training needs of those working with Aboriginal and CALD populations. This is followed by a discussion of the menu of evidence-based programs and the limitations of the evidence. While only 33 programs met the highest criteria of efficacy, many more programs have been developed but have not yet been tested sufficiently to include on the list of proven programs. The fact that these programs are not on the final list does not mean they are not effective; indeed, some of these may prove to be as effective (or even more effective) than those already on the list. This gap between promising and proven practices is common, and reflects the sheer number of interventions that have been developed, the difficulty in arranging independent trials of all of them, and the technical challenges to be overcome in testing these programs to the highest standards.

The penultimate section contains recommendations regarding evidence-informed decision-making, the menu of evidence-based programs, the tiered levels of prevention, CALD and Aboriginal populations and training and supervision.

The report concludes by noting that, although the principal focus of this evidence review was to identify evidence-based programs that are applicable to child welfare and child protection services, and can be incorporated in the *Roadmap for Reform,* what is apparent is that there are other important forms of evidence that need to be included. The development of the *Roadmap* should be based on an evidence-based *system*, including evidence regarding effective ways of identifying emerging child and family concerns and needs, and evidence regarding effective ways of integrating services so as to be able to respond in a holistic way to complex family issues.

A key finding of this review is that more attention needs to be paid to the development of high quality relationships between professionals and children, young people and their families. Relationships should be at the heart of the care system. For those who have suffered traumatic maltreatment at some stage of their lives, sustained supportive relationships represent the most effective form of treatment. For others who have not experienced maltreatment but are facing multiple challenges, positive relationships with service providers are the medium through which evidence-based programs such as those identified in this review can be delivered effectively.

Introduction

This report was commissioned as part of DHHS's Roadmap for Reform, a systematic approach to improving the Victorian child and family system, incorporating the statutory child protection system, out-of-home care and early intervention and prevention services for children and families experiencing vulnerabilities.

Underpinning the Roadmap for Reform is the vision of a service system with two key features:

- all state-funded programs and services are supported by scientific evidence of effectiveness, and
- these services are delivered on the basis of progressive universalism, that is, there is a tiered continuum of parenting and family support services, with progressively more intensive levels of support provided to children, young people and their families who have differing levels of need.

The purpose of this project is to identify evidence-based programs and practices in three main areas:

- universal and early intervention and prevention services,
- services that are responding to families brought to the attention of statutory child protection services with identified, very high risk factors that impact on their ability to keep their children safe, and
- programs that support foster and kinship carers and residential care staff to look after children suffering from traumatic stress through to programs that assist care leavers to successfully transition to independent living.

The specific objectives of this Project are two-fold:

- to define a draft menu of evidenced-based practices and programs relevant to the services outlined above, and
- to provide a set of recommendations to support the implementation of the menu in Victoria.

Outline of report

The paper begins with a consideration of evidence-based practice as it is commonly understood. This reveals that equating evidence-based practice with evidence-based programs or treatments does not capture its true multidimensional nature: properly understood, *evidence-informed practice* involves three key components: *evidence-based programs*, *evidence-based processes*, and *client and professional values and beliefs*. The next three sections describe each of these in detail, as well as the relationship between them. They are followed by a description of an *evidence-informed decision-making* model for combining the various sources of evidence in service delivery.

The paper then examines the implications for implementation from three perspectives: implementing evidence-informed practice at different levels of prevention, implications for workforce preparation, and implications for improving the menu of evidence-based programs. The paper concludes with recommendations and some final observations.

There are five appendices, all devoted to the menu of evidence-based programs. The first (Appendix A) provides an overview of the programs, and is designed to help users locate programs most likely to

meet their needs. The second (Appendix B) is the full menu, containing a detailed account of each program, grouped according to the level of service they address. The other three Appendices provide methodological information about the review process used to identify the programs.

Understanding evidence-based practice

The *Roadmap for Reform* envisages a future system where all state-funded programs and services are supported by scientific evidence of effectiveness. The term *evidence-based practice* is usually understood as the use of programs and interventions that have been proven to be effective through a particular set of methods – randomised controlled trials with replications and longitudinal follow ups, and systematic reviews of such trials. It has been argued that interventions that have not been subjected to these tests and shown to be effective should be avoided. This has led to the generation of lists of evidence-based programs that practitioners were advised or even required to choose from.

This approach has been criticised on several grounds. First, this form of evidence has some significant limitations (e.g. Barlow & Scott, 2010; Green & Latchford, 2012; Greenhalgh, 2012a; Greenhalgh & Russell, 2009; Hammersley, 2013; Pawson et al., 2011; Petr & Walter, 2005, 2009; Rogers & Vismara, 2008; Rosenbaum, 2010) – see Moore (2016) for a summary. One major limitation is that, on their own, evidence-based programs are insufficient to ensure better outcomes. For instance, in reviewing what we know about what works with complex families, Barlow and Scott (2010) conclude that

> … there is currently very little evidence to show that discrete, manualised packages can on their own prevent the recurrence of child abuse, and much to suggest that such interventions should be part of a broader approach that involves the provision of a long-term relationship underpinned by some of the theoretical concepts that are now indicated by recent aetiological models of child abuse. (p. 61)

Second, reducing evidence-based practice to lists of proven programs distorts the process. Fonagy et al. (2014) decry this practice:

> Historically, there has been a tendency to assume that a treatment can be 'branded' once and for all as an evidence-based practice, so that no further reflection on how or for whom it is to be implemented is necessary. This 'idealisation' evidence must be avoided at all costs, as the existence of evidence increases the chances of a treatment being effective but is by no means sufficient to ensure success. We now know that evidence-based practice cannot be assured by 'choosing' a treatment from a list of approved options. This is but a parody of evidence-based practice and tantamount to mistaking the cover of a book for its contents. (p. 4)

Third, definitions of evidence-based practice make it clear that evidence-based practice is not just a process of selecting from a list of proven strategies or programs, but a decision-making process that draws on multiple sources of evidence. This becomes apparent when we consider key definitions of evidence-based practice.

The idea of evidence-based practice was originally derived from medicine, where the notion of *evidence-based medicine* was championed by David Sackett and colleagues (Sackett et al., 1996, 2000) and defined thus: ‘Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values’ (Sackett et al., 2000). When evidence-based medicine was adopted for use in human services and rebadged as *evidence-based practice* (Littell, 2010), the three

key elements described by Sackett and colleagues were retained. For instance, the American Psychological Association (2006) defines evidence-based practice as 'the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences'. And in the early childhood intervention field, Buysse and Wesley (2006) define evidence-based practice as 'a decision-making process that integrates the best available research evidence with family and professional wisdom and values'. In other words, it involves a balance of scientific proof, family and professional wisdom, and family and professional values.

In this last definition, evidence-based practice is specifically described as a decision-making process. Indeed, this was also how David Sackett and colleagues envisaged evidence-based medicine – as a process that a clinician went through in choosing how best to help individual clients (Littell, 2010; Sackett et al., 2000). In fact, in all of these definitions of evidence-based medicine and evidence-based practice, there is the assumption that evidence-based practice involves the use (by practitioners and parents) of many sources and types of evidence in making decisions about how to address the challenges they face (Littell & Shlonsky, 2010; Petr, 2009). As Petr (2009) states, 'Social workers should not blindly apply or impose research findings to every individual client, but instead use their own experience as well as the client's preferences to honour client self-determination' (p. 8).

While there is general agreement about what the key sources of evidence are, there is no consensus on what they should be called. In this paper, we refer to the three sources of evidence as *evidence-based programs*, *evidence-based processes*, and *client and professional values and beliefs,* and to the overall process as *evidence-informed practice* [1], as shown in the Figure 1 (below).

Figure 1. Evidence-informed practice

[1] See Moore (2016) for a full discussion of relevant terminology.

The next three sections describe these three elements in more detail. They are followed by a description of an *evidence-informed decision-making* model for combining the various sources of evidence in service delivery.

Evidence-based programs

Evidence-based programs refer to interventions or programs that have been shown through rigorous formal testing to be effective in building client competencies and changing behaviour and functioning. Programs that have been proven to be effective in reducing child maltreatment rates or ameliorating the effects of maltreatment are listed in the evidence-based menu.

Because of the limited time available for this review, a rapid evidence assessment (REA) methodology was used to identify relevant programs. (Full details of the review methodology, the databases searched, and the evidence criteria used can be found in Appendix C.) This type of assessment uses similar methods and principles to a systematic review, but does not involve an exhaustive search of the literature. As such, the rapid review approach to evidence assessments may result in missing some relevant information (Ganann et al., 2010). Nevertheless, the approach is appropriate when a targeted search is required to identify relevant literature within a short timeframe.

Following examination of almost 50 key review papers, a 'long list' of more than 190 potentially relevant programs was constructed. This list of programs was then narrowed to those evaluated with at least one Randomised Controlled Trial (RCT) demonstrating a positive impact on the outcomes of interest. Those with the strongest research evidence were considered 'best-practice' and selected for inclusion in the menu. Several 'promising' programs were also considered for inclusion, with special consideration given to those implemented and evaluated in Australia.

A total of 33 programs are included in the final menu. (See Appendix A for an overview of the programs, and Appendix B for the full menu, containing a detailed account of each program, grouped according to the level of service they address.). The majority of these focus on families who are either at serious risk of child maltreatment, are receiving statutory child protection services, or have children in out of home care. This reflects a general focus on treatment rather than prevention or very early intervention. Similarly, only a few programs were identified at the other end of the spectrum, demonstrating effective interventions for the transition to independent living. Regarding the different goals of intervention, the key findings were as follows:

- *Reducing maltreatment.* The majority of programs demonstrating some evidence of a reduction in child maltreatment (or its potential) utilised a home visiting approach. All programs in this category included a component focussing on positive parenting skills.
- *Placement permanency / reunification*. Programs demonstrating a positive impact on permanency of placements or reunification with the birth family presented a mix of home-visiting and group-based interventions. Most involved efforts to improve child behaviour and/or parenting practices.
- *Social and/or emotional wellbeing and health behaviours*. A variety of programs positively impacting social and/or emotional wellbeing and health behaviours were identified. These include a range of home visiting, group education, and family therapy approaches.

- *Transition from out-of-home care.* There appear to be a variety of programs currently implemented to assist children currently in out of home care with their transition to independent living, but very few of these have been evaluated in RCTs. Those that have demonstrated some promise with respect to post-secondary education and psychosocial outcomes. Whether these programs also positively impact other aspects of independent living, such as housing and employment, remain to be seen.
- *Programs for CALD and Aboriginal populations*. Only two programs specifically tailored to Australian Culturally and Linguistically Diverse groups met inclusion criteria. Neither has demonstrated effectiveness with an RCT evaluation.

This menu is not intended as an exhaustive list of programs that may benefit children and families considered at risk of or facing child maltreatment problems. For various reasons, not every effective and relevant program could be identified. First, many programs currently being implemented may be effective, but they may not yet have been evaluated. Second, the initial searches were contained to recent literature reviews in a limited number of databases and key websites. Third, time constraints meant program selection was limited to those with the strongest research evidence in the outcome areas listed above. Not all interventions can be tested using the strongest designs (for pragmatic and ethical reasons, for example). Nevertheless, such interventions may be effective. Finally, it should be noted that programs targeting broader risk factors (e.g., housing and employment stress, parent mental health, substance abuse, domestic violence) and systemic changes are likely to be necessary to address child maltreatment and its associated problems. Consideration of such programs was beyond the scope of this project, but should be taken into account in policy and planning activities.

This menu of evidence should not be considered a static document. Developments in program design, implementation, and evaluation will continue and, as such, new programs that are equally or more effective and efficient may emerge. Similarly, it is possible that programs currently recognised as best practice or promising may not be so in the future. Evidence of ineffectiveness or damaging effects may also emerge and checks for such developments should be conducted before programs are implemented.

The next section summarises what is known about the second element of evidence-informed practice – e*vidence-based processes*.

Evidence-based processes

Evidence-based processes refer to the way in which service providers and the service system as a whole engage and work with families, individually and collectively. In understanding the role of evidence-based practices, there are three questions we need to address:

- Is there evidence that the *way* in which services are delivered (as distinct from *what* services are delivered) matters for outcomes?
- If so, what are the key practices that produce best results?
- What is the relationship between evidence-based practices and evidence-based programs?

Is there evidence that the way in which services are delivered matters for outcomes?

The evidence to address this question comes from a variety of sources:

- research on the neurobiology of interpersonal relationships
- research on what families experiencing vulnerabilities want from services,
- research on psychotherapy efficacy,
- research on effective help-giving practices, and
- research on family-centred practice and family-centred care.

Neurobiology of interpersonal relationships

We are intensely social creatures, and our brains are shaped by relationships, for good or otherwise (Lieberman, 2013). This is particularly true for children, but relationships continue to play an important role in shaping our health and well-being throughout our lives. The research on the neurological functioning and development (Davidson & Begley, 2012; Doidge, 2007; LeDoux, 2003; McGilchrist, 2009; Panksepp, 1998; Siegel, 2012), and the neurobiology of interpersonal relationships (Cozolino, 2010, 2014; Schore, 2012a, 2012b) has shown that our brains constantly communicate with other people's brains via subconscious high-speed pathways. These enable us to register others' feelings and states of mind, and enables them to register our own feelings and states of mind, which is why we cannot fake being interested, caring or empathetic. These constant neurobiological interactions are the mechanism whereby people's brains can be rewired over time.

The relevance of these findings lies in the fact that all forms of human services are essentially relational – they involve a relationship between a service provider (or providers) and a service user (or users). In the case of welfare services, the providers are typically social workers and the users are parents and other caregivers. In the case of mental health services, the providers are therapists, psychologists and psychiatrists and the users include children and young people who have been adversely affected by traumatic experiences. Given the powerful neurobiological effects of the interactions involved in these relationships, they should be regarded as the foundation of effective service delivery.

A particularly important feature of our neurobiology is the way that relationships affect other relationships, a phenomenon known in the mental health field as *parallel process*. Parallel processes operate at all levels of the chain of relationships and services, so that our capacity to relate to others is supported or undermined by the quality of our own support relationships. This flow-on effect can be seen in the relationships between early childhood professionals and parents of young children: we model for parents how to relate to their young children by the way we relate to them (Gerhardt, 2014; Gowen and Nebrig, 2001). Relationships form a cascade of parallel processes, so that the quality of relationships at one level shapes the quality of relationships at other levels (Moore, 2006).

This has implications for practitioners working with complex families – their capacity to be effective in the highly charged and challenging role depends to a significant extent upon the quality of their own personal and professional supports. As Scott et al. (2007) have noted, the practitioner-parent relationship is embedded within an organizational context which influences the relationship through the nature of the physical setting, its resources, the service role and mandate, and agency climate and morale. They suggest that organisations can enhance positive worker-parent partnerships through:

- creating a culture of inquiry and reflection
- selecting the right staff
- supporting staff through good supervision and training

- giving staff enough time to develop relationships (Scott et al., 2007).

The importance of effective supervision is frequently highlighted in reviews of the research and practice literature (eg. Carpenter et al., 2012; Fauth et al., 2010).

Lessons from families experiencing vulnerabilities

The second body of evidence comes from studies of families who are marginalised and experiencing vulnerabilities, focusing on those features of service delivery that are associated with more successful engagement with families and greater 'take up' of services (Boag-Munroe & Evangelou, 2012; Cortis et a., 2009; Doel, 2010). These studies show that services delivered in certain ways are consistently more effective in engaging families, building parental competencies, and improving child and family outcomes (CCCH, 2010; Moore et al., 2012).

These process variables appear to be of particular importance for the families experiencing the most vulnerabilities, who are less likely to make use of professional services that do not possess such qualities. Reviews of the evidence (Centre for Community Child Health, 2010; Moore et al., 2012) suggest that what vulnerable and marginalised families need are services that:

- help them feel valued and understood, and that are non-judgmental and honest,
- have respect for their inherent human dignity, and are responsive to their needs, rather than prescriptive,
- allow them to feel in control and help them feel capable, competent and empowered,
- are practical and help them meet their self-defined needs,
- are timely, providing help when they feel they need it, not weeks, months or even years later, and
- provide continuity of care – parents value the sense of security that comes from having a long-term relationship with the same service provider.

More detailed accounts of working with families and children experiencing vulnerabilities can be found in Arney and Scott (2010), Ensher and Clark (2011), Landy and Menna (2006), and Roggman et al. (2008).

Efficacy in psychotherapy

The third source of evidence comes from studies of the efficacy of various forms of psychotherapy. This research has shown that all forms of psychotherapy are effective with some people, and that no single model can be shown to be more effective than others (Duncan et al., 2010; Moloney, 2016). The evidence indicates that psychotherapies work not because of the unique contributions of any particular model of intervention but because of a set of common factors or mechanisms of change that cuts across all effective therapies – known as the *common factors approach* (Sprenkle et al., 2009). The two principle features of successful psychotherapy, regardless of the model used, are:

- the *therapeutic alliance* (the joint working relationship between the therapist and the client), and
- the *personal qualities* of the therapists themselves.

A third factor that is strongly associated with good outcomes in therapy is the systematic use of client feedback in establishing and maintaining a sound therapeutic alliance (Fonagy et al., 2014; Moloney, 2016).

Family-centred practice and family-centred care

A fourth source of evidence comes from studies of family-centred practice and family-centred care. Numerous statements of the key principles of family-centred practice and family-centred care exist (e.g. Bailey et al., 2012; Dunst, 1997; Kuo et al., 2012; Moore & Larkin, 2006; Rosenbaum et al., 1998; Trivette & Dunst, 2000). Bailey et al. (2012) summarise the key features of a family-centered approach thus:

> The essential assumption of a family-centred approach is that young children cannot be viewed apart from their families, nor can services be provided without a consideration of the family context. In fact, families are seen not as clients receiving services but as partners in making decisions about goals and activities. Core principles of a family-centred approach include focusing on family strengths, respecting family diversity and values, encouraging family decision making and empowerment, communicating with families in an open and collaborative fashion, adopting a flexible approach to service provision, and recognizing the value of informal support systems.

There is strong evidence to support the effectiveness of family-centred practice and care approaches. Recent literature reviews and meta-analyses of research across a wide range of medical and early intervention service sectors have consistently shown that family-centred practices have positive effects in a diverse array of child and family domains, such as more efficient use of services, decreased health care costs, family satisfaction with services, family well-being, building child and family strengths, parenting practices, and improved health or developmental outcomes for children (American Academy of Pediatrics, 2012; Bailey et al., 2007; Dempsey & Keen, 2008; Dunst et al., 2007, 2008; Dunst & Trivette, 2009; Gooding et al., 2011; Kuhlthau et al., 2011; McBroom & Enriquez, 2009; Piotrowski et al., 2009; Raspa et al., 2010; Rosenbaum et al., 1998). In addition, there are benefits for professionals in the form of stronger alliances with families, improved clinical decision-making, improved follow-through, greater understanding of the family's strengths and caregiving capacities, more efficient and effective use of professional time and health care resources, greater professional satisfaction, and greater child and family satisfaction (American Academy of Pediatrics, 2012).

Effective help-giving

Another way in which the processes of service delivery have been analysed is in terms of the key features of effective helping (Braun et al., 2007; Dunst & Trivette, 2007, 2009). On the basis of their research over 20 years, Dunst and Trivette (2009) identify twelve principles of effective help-giving. Help-giving is more likely to be effective when:

- it is both positive and proactive and conveys a sincere sense of help giver warmth, caring, and encouragement
- it is offered in response to an indicated need for assistance
- it engages the help receiver in choice and decisions about the options best suited for obtaining desired supports and resources

- it is normative and typical of the help receivers' culture and values and is similar to how others would obtain assistance to meet similar needs
- it is congruent with how the help receiver views the appropriateness of the supports and resources for meeting needs
- the response-costs for seeking and accepting help do not outweigh the benefits
- it includes opportunities for reciprocating and the ability to limit indebtedness
- it bolsters the self-esteem of the help receiver by making resource and support procurement immediately successful
- it promotes, to the extent possible, the use of informal supports and resources for meeting needs
- it is provided in the context of help giver-help receiver collaboration
- it promotes the acquisition of effective behaviour that decreases the need for the same type of help for the same kind of supports and resources
- it actively involves the help receiver in obtaining desired resource supports in ways bolstering his or her self-efficacy beliefs.

Conclusions

These convergent sources of evidence all point to the same overall conclusions: *how* services are delivered is as important as *what* is delivered (Davis & Day, 2010; Dunst & Trivette, 2009; Moore, 2014), and the quality of the relationships between practitioners and parents are central to achieving the objectives of services (Bell & Smerdon, 2011; Braun et al., 2006; Scott et al., 2007). Bell and Smerdon (2011) use the term Deep Value to convey the importance of the practitioner-parent relationship:

> Deep Value is a term … that captures the value created when the human relationships between people delivering and people using public services are effective. We believe that there are real benefits in delivering public services in ways that put the one-to-one human relationship at the heart of service delivery. In these relationships, it is the practical transfer of knowledge that creates the conditions for progress, but it is the deeper qualities of the human bond that nourish confidence, inspire self esteem, unlock potential, erode inequality and so have the power to transform.

(It is worth noting there is one important omission from the list of sources of evidence reviewed above: the crucial role of the evidence-based *processes* identified is not reflected in studies of evidence-based *programs* such as those included in the evidence menu. While studies of programs may acknowledge the importance of the relationships between practitioners and parents, they rarely regard the relationship as integral to the intervention itself. As a result, formal trials of programs do not usually involve any measurements of the quality of the practitioner-parent relationships, and are therefore unable to tell what contribution these relationships made to the outcomes. It is possible that some of the programs that have only shown to be modestly effective may be much more effective when delivered within the context of an effective therapeutic alliance between practitioner and parent, and much less effective when the relationship is less compatible.)

What are the key features of evidence-based processes?

The second question of interest concerns what we know about the key features of evidence-based processes. A number of key elements of effective service delivery processes have been repeatedly identified in the research literature (CCCH, 2010; Moore et al., 2012). Regardless of the focus or content of the intervention, effective programs:

- are relationship-based
- involve partnerships between professionals and parents
- target goals that parents see as important
- provide parents with choices regarding strategies
- build parental competencies
- are non-stigmatising
- demonstrate cultural awareness and sensitivity and
- maintain continuity of care.

The importance of relationship-based practice emerges in all reviews of the research evidence regarding welfare services (eg. Barlow & MacMillan, 2010; Barlow & Scott, 2010; Ruch et al., 2010; Scott et al., 2007; Thoburn et al., 2009). As Barlow and Scott (2010) have argued:

> 'the answer to working effectively with families in which there is concern that a child is being harmed, lies not in the whole-sale adoption or implementation of evidence-based manualised programmes; rather, such programmes need to be implemented as part of a broader approach that is underpinned by a recognition of the importance of a long-term and supportive relationship.' (p. 59)

Establishing positive partnerships between practitioners and parents of young children is also regarded as central to achieving the objectives of services (Roose et al., 2013; Scott et al., 2007).

The key qualities needed for relationship-based and partnership-based practice are well understood. Scott and colleagues (2007) nominate four key practitioner qualities as central to effective working relationships: empathy, respect, genuineness and optimism. Others (eg. de Boer & Coady, 2007; Davis and Day, 2010) identify similar qualities.

What is the relationship between evidence-based processes and evidence-based programs?

The third question of interest concerns the relationship between the evidence-based processes and evidence-based programs. As we have seen, when working with families facing multiple challenges, successful and sustained engagement with families is the precondition for delivering programs that build parental competencies and create change. However, engagement in itself does not lead to significant change or improved outcomes: it constitutes a necessary but not sufficient condition for change (Barnes, 2003; Barnes & Freude-Lagevardi, 2003). Change only occurs if parents learn new skills and behaviours that enable them provide more responsive, more stimulating and safer home environments for their children. This is where evidence-based programs have their vital part to play – they provide the proven strategies for building parental capacity and changing caregiving behaviours.

Thus, the practitioner-client relationship is both an end in itself, and a core part of the process or mechanism through which change is achieved (Barlow & Scott, 2010; Moore et al., 2012). The practitioner-parent relationship is therefore an intervention in the sense that it is being used to facilitate change in the family (Barlow & Scott, 2010) – it is the medium through which effective programs can be delivered. This implies that a practitioner should be considered 'not only as a *provider* of treatment, but also as a *means* of treatment' (McKay et al., 2006).

Thus, evidence-based processes and evidence-based programs are complementary – both are insufficient on their own. As Barnes (2003) notes:

> … if a reasonably satisfying therapeutic relationship cannot be established between intervenor and client, then the duration or intensity of an intervention program may be of little consequence. The same applies if the intervention model fails to match the parent's needs; if the parent is not involved in the decision-making or disagrees with any prescribed program goals/outcomes.

If the parent does not use the program, then it does not matter how strong the evidence for that program is, it will not be effective in changing the caregiving environments that parents provide.

Evidence regarding working with complex families and complex trauma

The evidence summarised above draws on various sources (including social work) and applies to human services in general. Do the findings also apply to the complex families that welfare services seek to help?

The families that demand most time from welfare services are *complex families*, that is, families facing multiple challenges and struggling to provide their children with adequate care and protection. The evidence-based practices we have identified undoubtedly apply to these families, and indeed are even more crucial than for families who are better resourced and facing fewer challenges.

However, within these families there will be some parents as well as some children who have suffered *complex trauma*, and these present particular challenges for welfare services (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Barlow & Scott, 2010). Complex trauma results from exposure early in life to multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (eg, sexual or physical abuse, war, community violence) (Cook, 2005; van der Kolk, 2005). These exposures often occur within the child's caregiving system and include physical, emotional, and educational neglect and child maltreatment beginning in early childhood (Barlow & Scott, 2010; van der Kolk, 2010). Such exposures can have profoundly disruptive effects on development, and present the greatest challenges in working with those affected.

The best form of treatment to address complex trauma in parents is not a proven intervention program, but a sustained relationship that can meet some of the unmet dependency needs of clients, thereby helping them to function better in their parental role, and help clients to develop understanding about the impact of their own life experiences on their parenting (Barlow & Scott, 2010). How to build and sustain such relationships is a challenge for the service system.

The evidence indicates that, while the key features of effective relationship-based practice remain true for complex families, there are additional challenges involved. First, there is a greater need for

practitioner-parent relationships to be long term – it takes time to build trust and establish the kind of therapeutic relationship that ultimately helps reconfigure deep-seated parental cognitive, emotional and behavioural patterns (Barlow & Scott, 2010; Fauth et al., 2010; Thoburn et al., 2009). Second, there needs to be a greater attention to establishing and maintaining boundaries in relationships – clear boundaries are needed to contain parental anxieties and ensure that the child's needs stay in sharp focus (Fauth et al., 2010).

Children in care are especially vulnerable to the effects of childhood traumatic stress, and welfare systems must address the needs of children in care by treating not only the symptoms of their trauma but also the underlying causes (Barton et al., 2011; Klain & White, 2013). To support children experiencing complex trauma, there is a growing recognition of the need for all services involved with young children to provide trauma-informed care (Wall et al., 2016). Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage (Evans & Coccoma, 2014; Wall et al., 2016). A growing body of scientific literature indicates the success of trauma-informed child welfare systems in treating child traumatic stress (Klain & White, 2013). While there are some well-established models of how to implement trauma-informed practices (eg. Klain & White, 2013; Steele & Machiodi, 2012), there is still much work needed to establish what forms of trauma-informed care are needed by different groups, what can be expected of practitioners, and how they can be training in the necessary skills (Wall et al., 2016). Efforts to introduce trauma-informed care across whole systems and provide appropriate training are described by Kramer et al. (2013), Ko et al. (2008), and Layne et al. (2011).

In reviewing what we know about what works with complex families, Barlow and Scott (2010) conclude thus:

> In summary, there is currently very little evidence to show that discrete, manualised packages can on their own prevent the recurrence of child abuse, and much to suggest that such interventions should be part of a broader approach that involves the provision of a long-term relationship underpinned by some of the theoretical concepts that are now indicated by recent aetiological models of child abuse.

Overall conclusions regarding evidence-based processes

From the evidence just reviewed, it is clear that, for human services to be effective, it is not just the interventions or programs that need to be evidence-based, but also the processes whereby practitioners engage and work with parents and families. This means that ensuring that practitioners are able to build effective working relationships with parents and caregivers should be a major focus of service system design, organisational structures, job descriptions, and professional development.

For instance, we also need to be mindful of parallel processes and the importance of ensuring that front-line workers are supported in ways that enable them to be effective practitioners. Just as parents need to have people caring for them if they are to care for their children, so professionals need caring support from others if they are to establish and maintain responsive and caring relationships with parents and families. They can get this support from various sources, including their own partners and families, but in work settings the two main sources of support are their colleagues and their managers or supervisors.

The review of evidence-based processes also raises a number of questions about how welfare services and service providers make decisions about what evidence-based programs to use. The evidence highlights the importance of building partnerships with parents, of addressing issues that are of most salience to parents, and of building parental capacities. This implies that, while professionals may have developed and tested evidence-based programs, the decisions about which programs are deployed depends upon a process of relationship-building, goal selection and strategy negotiation.

This process inevitably involves *client and professional values and beliefs*, the third element of evidence-informed practice.

Client and professional values and beliefs

For services to be effective, they must not only be centred on evidence-based processes and evidence-based programs, but must also reflect the values of clients and the outcomes that are important to them. As defined by Sackett et al. (2000), *patient values* refer to the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient. Everyone has values, even if these are not well articulated or consistent, and these guide our perceptions and responses to people and events (Haidt, 2012). This is as true of professionals as it is of parents (McCarthy et al., 2010). If professionals are not aware of their values (e.g. values regarding ethnicity, cultural differences, sexual orientation) and how these can affect their responses to particular parents, then they may find themselves behaving in ways that undermine the relationship. It is important that professionals are aware of their values and learn to manage the responses they trigger so that they do not compromise their work.

There is consistent evidence that services are less effective if they do not address issues that clients see as important, do not address outcomes they value, and do not use strategies that clients are happy to use (Affleck et al., 1989; Barnes & Freude-Lagevardi, 2003; Moore et al., 2012; Sprenkle et al., 2009). One of the themes repeatedly emerging from studies of effective processes is the importance of addressing the needs that parents and caregivers – rather than professionals – identify as important. For instance, in the psychotherapy literature, there is consistent evidence that therapists need to adapt to client preferences, expectations and characteristics if they are to be effective (Sprenkle et al., 2009). Providing social support to parents and caregivers in response to an indicated need for help is associated with positive consequences, whereas providing social support in the absence of an indicated need for help has negative consequences (Affleck et al., 1989).

To ensure that the outcomes targeted are those that are important to clients, professionals need to build genuine partnerships with clients. As noted in the review of evidence-based processes, two of the key elements of effective service delivery processes were that they involve partnerships between professionals and parents, and target goals that parents see as important (Moore et al., 2012).

Basing services on the outcomes that are valued by clients is in contrast to the commonly used approach of basing services on a pre-selected evidence-based program. The reason for focusing first on outcomes valued by clients – rather than interventions chosen by professionals – is that it is very possible that a particular intervention (even if shown to be effective by the most rigorous research standards) may be rejected by clients because it does not lead to outcomes they value. As our ideas about what we are trying to achieve evolve, some ‘proven’ strategies or interventions may no longer be the best (or even relevant) option because they do not achieve the ends professionals and clients now have in mind.

Outcomes-based approaches 'start with the end in mind', that is, they begin by identifying the outcomes to be achieved and work backwards from there (Moore, 2006, 2010). Outcomes-based approaches need to take into account the *beliefs* of parents and professionals. There is evidence that both parental and professional beliefs play and important role in effective service delivery (Dunst et al., 2007, 2008). *Parents' beliefs* play an important mediating role in achieving positive outcomes. These beliefs take two forms: belief in the intervention plan and belief in their personal ability to implement the intervention as planned (parental efficacy beliefs). Family-centred practices are not directly related to child wellbeing outcomes but rather indirectly mediated by these beliefs. This is thought to be the case because family-centred practices strengthen parental beliefs about their own efficacy, and parents who feel empowered about their parenting capabilities are more likely to provide their children development-enhancing learning opportunities (Dunst et al., 2007, 2008).

Professional values and beliefs also play an important role in the adoption and implementation of effective practices (Trivette et al., 2012a, 2012b). These also take two forms: belief in the efficacy of the intervention selected, and belief in the client's ability to implement the intervention plan.

Overall, the evidence indicates that parental and professional values and beliefs play an important role in determining whether interventions are acceptable to clients, and therefore whether the interventions are likely to be implemented. Regardless of their strength of evidence, programs are unlikely to be effective if the clients do not see them as addressing their most pressing concerns, or that do so in ways that are inconsistent with family values, or that are not easily implementable in their particular circumstances.

Conclusions

Overall, the evidence regarding the three elements considered above – evidence-based programs, evidence-based processes, and client and professional values and beliefs – indicates that all three make important contributions to achieving positive outcomes. Before considering how to incorporate these three elements in practice, we need to clarify our terminology. The common term *evidence-based practice* is confusing, partly because it is frequently understood as referring only to *evidence-based programs*, and also because it is easily confused with the term *evidence-based processes* as used in the discussion above. To resolve this dilemma, we will follow the suggestion of a number of researchers (Bowen & Zwi, 2005; Littell & Schlonsky, 2010; Rogers, Williams & Stevens, 2008) and use the term *evidence-informed practice* for the multidimensional model that integrates 'evidence' from different sources.

As noted earlier, evidence-informed practice should be understood as a decision-making process, a way of blending the three major sources of 'evidence' in practice (Greenhalgh et al., 2014; Littell & Shlonsky, 2010; Mitchell, 2011; Petr & Walter, 2005, 2009; Schorr & Farrow, 2011). We will follow Littell and Shlonsky (2010) in calling this process *evidence-informed decision-making*.

What follows is an outline of a framework for applying evidence-informed decision-making in practice.

Evidence-informed decision-making

This review of a broadly conceptualised understanding of evidence-informed practice has shown that all three elements play a significant role in determining whether interventions in the human services are effective or not. Relying solely on evidence-based programs will lead to modest benefits at best and fail to benefit some people at all, particularly those experiencing the most vulnerabilities. To help such families better, we need services that engage them effectively and that address issues of personal significance to them. However, we should also note that basing services solely on effective engagement processes or on client values will not produce significant change either: *all three elements of evidence-informed practice are needed if interventions are to be fully effective.*

However, combining all of these different factors in the decision-making process is not a simple matter. What is needed is a decision-making or service-delivery framework to guide work with clients. Based on an analysis of evidence-based practice, Moore (2016) suggests that the following should be included in such a framework.

- First, we need to align program content and methodology with client values, addressing what the client sees as most important for them.
- Second, we need to be attuned and responsive to the views and circumstances of the clients, and engage them as partners.
- Third, we need to use a purposeful process of joint decision-making in identifying goals to work on and choosing strategies to use.
- Fourth, we need to be able to offer parents the choice of a range of evidence-based strategies and program modules to address the goals that have been agreed.
- Finally, we need to monitor continuously the implementation and effectiveness of the strategies chosen, and make immediate corrections when it is apparent that they are not being met.

Various decision-making models have been proposed. These include:

- the Multidimensional Evidence-Based Practice model (Petr & Walter, 2005; Petr, 2009)
- the Collaborative Family Work model (Trotter, 2013)
- the implementation approach advocated by Fixsen et al. (2005) and Wiggins et al. (2012)
- the evidence-based practice decision-making process developed in medicine by Straus et al. (2005).

The approach recommended by Fixsen et al. (2005) and by Wiggins et al. (2012) begins by selecting ‘the most appropriate program for a local area’ (Wiggins et al., 2012), then proceeds through a series of steps to train staff, develop organisational supports, monitor progress, and evaluate program fidelity and outcomes. The emphasis is very much on the selection and implementation of evidence-based programs, and on ensuring program fidelity.

The decision-making process developed in medicine by Straus et al. (2005) (called *client-oriented practical evidence search* or COPES) also begins with a focus on program selection. This approach involves five steps: formulating a well-designed question; identifying evidence-based resources that answer the question; critically appraising the evidence to assess its value; applying the evidence with guidance from client preferences, the clinical state, practitioner expertise; and re-evaluating the

application of the evidence to modify future practices. This approach includes client preferences as well as practitioner expertise, but only after the professionals have selected the questions to be addressed and identified the evidence-based strategies to address them.

While these approaches do not ignore the importance of client engagement and values altogether, their starting point and main focus is on the role of professionals in selecting and implementing evidence-based programs. As articulated in this paper, before we reach any consideration of programs and their implementation, we must engage with and build partnerships with clients, and establish what their values and priorities are.

This means embedding the evidence-based decision-making process in a broader human services framework. One such model being developed by CCCH (Moore, 2016) involves the following steps.

- ***Step 1. Begin to build a partnership relationship with the family*.** The key qualities of effective relationships are engagement, attunement and responsiveness, and the key skill is reflective listening. The process of building a sound relationship is ongoing, and is built over time through a process of repeated reconnections and feedback.
- ***Step 2. Explore what outcomes are important to the family.*** This involves an exploration of family values and circumstances, and what achievable change would make the most difference to their lives. Finding out what matters most to the family is critical, but it is also important that, over time, the professionals also share what they see as important outcomes. The final decision, however, always rests with the family.[2]
- ***Step 3. Agree what outcome will be the focus of work with the family***. Identify how they will know when the outcome has been achieved, and how this will be measured. The outcomes chosen by families initially may not be what the professionals would have chosen, but it is important to respect their first choices as a basis for building a sound partnership. With continued mutual sharing of information, the choices that the family makes should become progressively better informed.
- ***Step 4. Explore what strategies are available for addressing the outcomes chosen.*** This involves exploring with the family what strategies they already know about or use, as well as sharing with them information about what evidence-based strategies are available. The emphasis here should be on identifying and building upon existing family strengths and resources, as well as on building new competencies, and promoting the family's capacity to meet the needs of family members.
- ***Step 5. Agree on what strategy or strategies will be used.*** The strategies should be acceptable to the family and able to be implemented in their family circumstances. The result should be an action plan that describes the outcomes and strategies chosen, how the implementation will be monitored, and what roles the parents, professionals and any others will play.
- ***Step 6. Monitor the process of intervention implementation***. During the actual implementation phase, the role of the professional is to support the family as they implement the strategy, and to help them make any necessary adjustments. The issues to be addressed are

[2] The only exception to this is when there are concerns about child safety. In these situations, practitioners need to work with families to accept certain goals even if they are not the goals nominated by the family at that time. Family initiated goals can be explored concurrently and the strategies for all goals developed with and chosen by the family.

whether the strategies chosen are able to be implemented as intended, and whether they are being implemented with program fidelity. Any problems identified should be addressed promptly and the plan modified as required. It is important not to persist with strategies that are not working or are causing undue stress.

- ***Step 7. Review the process of implementation.*** In addition to the ongoing support and monitoring of the implementation, time should be made for a review of action plan. The key questions are whether the strategy has been able to be implemented and everyone has been able to contribute as planned. If not, then Steps 4 and 5 should be revisited. This is also a time for reviewing the parent-professional partnership. The professionals should be seeking feedback as to whether the parents feel their views are being heard and respected, and whether they are being helped to develop new competencies.
- ***Step 8. Monitor the intervention outcomes***. In addition to monitoring the processes involved in implementation, it is also important to monitor the actual outcomes. The role of the professional is to help the family uses measures identified earlier (Step 3) to check whether the strategies produced the intended changes. Family capacities and circumstances vary so much that it is impossible to be sure that any particular strategy, even one that has been proven effective elsewhere, will work for a particular family. Any indication that a strategy is not effective or is even causing harm in some way should be a signal for immediate review.
- ***Step 9. Review the outcomes.*** At an agreed point, a review of the whole intervention plan should be undertaken by the professional and parents. The main questions to be addressed are whether the desired outcomes were achieved, and, if not, then why not. This is also a time for a general reflection on what has been learned – by the family (what new skills have they developed?) as well as by the professional (what new strategies did they discover?).

Although the framework is presented as a series of steps, this is a schematic representation only: in practice, the steps are not discrete, and the different processes flow into one another. In addition, progress through the steps is not always sequential, as there will sometimes be a need to circle back and repeat some earlier steps as part of a process of refocusing.

At the heart of this framework lies the partnership relationship. This is the medium through which practical help is provided and positive changes made. The process described in the framework begins with engagement and tuning into family values and priorities, rather than with professionals deciding beforehand what the family needs and what strategies are most appropriate for meeting those needs. Evidence-based programs and strategies have an important role to play, but always in the context of family values and priorities. Information about such programs is not introduced until a partnership has been established and the professional has understood the family values and circumstances.

The process described allows for constant adjustments based upon feedback. It is not assumed that the strategies will always work in the ways intended, and indeed assumes that there may need to be modifications. This is a strength rather than a weakness, as the process of constant adjustments makes it more likely that the interventions will be manageable for the family and ultimately effective.

This service framework is generic, in that it can be used by an individual practitioner or team working with a client or family, an agency working with groups of clients or families, a network of services working with a community, or even a government department working with service networks. Whatever the context, the use of this framework should maximise clients' 'take-up' of the service (Moore, 2016).

Implementing evidence-informed practice at different service levels

Service systems are usually described in terms of a hierarchy, with three levels usually being identified; universal or primary services, targeted or secondary services, and indicated or tertiary services (CCCH, 2006; Axford & Barlow, 2013). For the present project, six levels of service were specified.

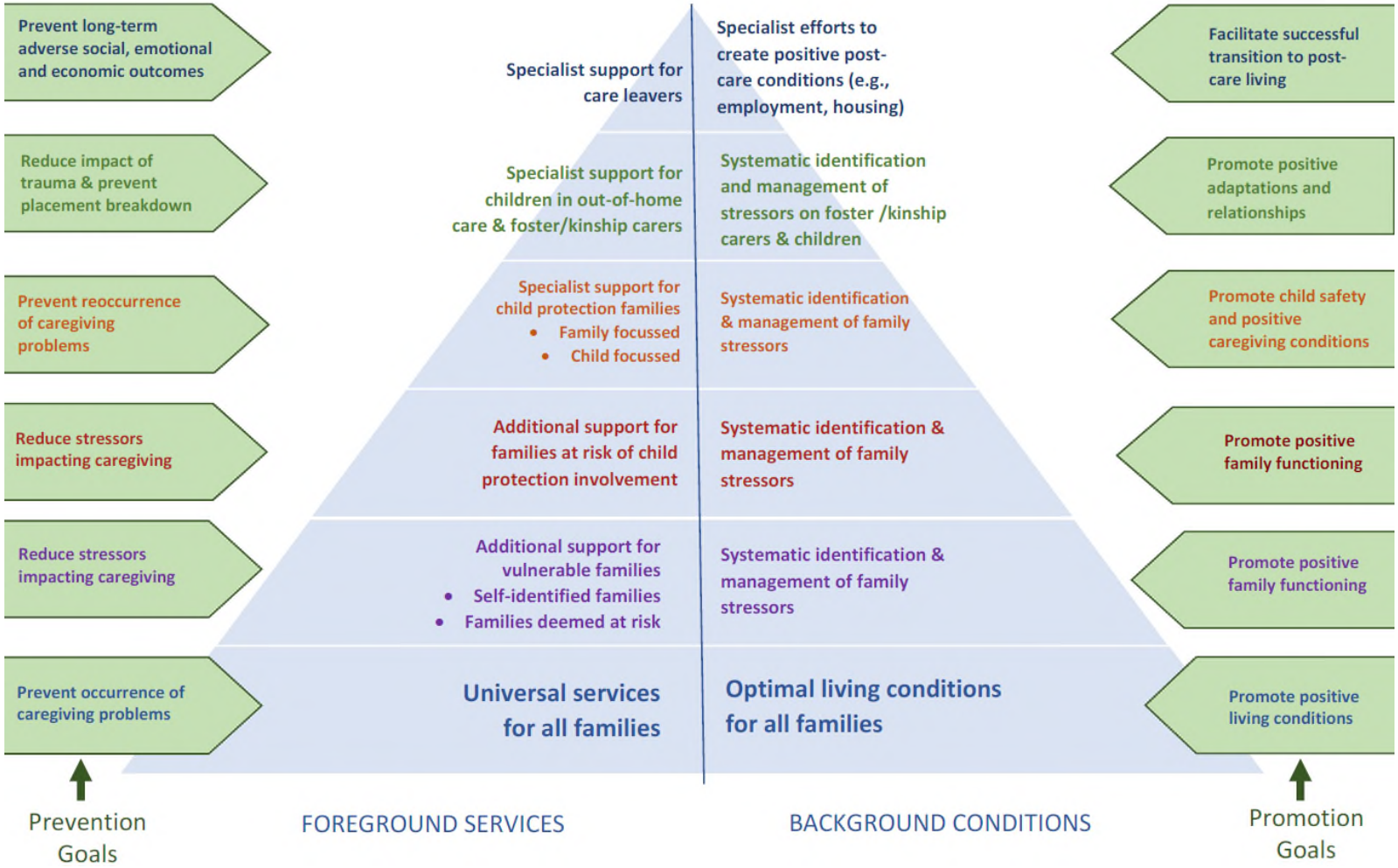
Universal / primary	• Families who function well
Targeted / secondary	• Families who have some difficulties • Families at risk of child maltreatment
Indicated / tertiary	• Families receiving statutory child protection services • Children living in out-of-home care • Care leavers

We propose to reframe the service levels in terms of the service provided rather than the target group, and added a seventh level – a form of universal intervention that involves providing positive conditions for all families.

Universal / primary	• Providing positive conditions for all families • Providing services for all families
Targeted / secondary	• Providing additional support to families facing extra challenges • Providing specific support for families at risk of child maltreatment
Indicated / tertiary	• Providing support to families receiving statutory child protection services • Providing support services to children living in out-of-home care • Providing support to care leavers

It should be acknowledged that, in the child welfare area, the distinctions between universal, targeted and indicated levels of services do not fully capture the many different pathways that children and young people can follow (e.g. children who move in and out of care), but are indicative only. A way of conceptualising what is involved at each level is shown in Figure 2 (next page). This shows the prevention and promotion goals that are applicable at each level of service, as well as both the direct ('foreground') services to children, young people and families, and the ('background') causal conditions that should be addressed. (Foreground and background factors are discussed in more detail on the next page)

PROGRESSIVE FRAMEWORK OF PREVENTION AND PROMOTION ACTIVITIES FOR POSITIVE FAMILY FUNCTIONING



In what follows, each of these levels of service is discussed – what's involved, what the rationale and evidence is, and what issues and implications are, and recommendations.

Providing positive conditions for all families

This involves efforts to provide all families with the conditions they need to be able to raise their children as they (and we) would wish. The focus of action at this level is on building positive social networks and supportive communities, providing healthy urban environments, ensuring access to affordable and suitable housing, ensuring employment opportunities and financial support, accessible transport, and providing family-friendly and easily accessible local facilities and services (e.g. libraries, swimming pools, green spaces).

This can be regarded as a form of universal provision in that it is a total population approach, aimed at all parents. However, what is *not* involved at this level is the provision of any health or welfare programs and services.

Rationale and evidence[3]

There is widespread consensus that the best way to ensure positive outcomes for children is to prevent poor parenting practices by providing children and families with the conditions and assistance they need before problems escalate into crises (Braveman et al., 2011; Cohen et al., 2010; Cowen, 2000, 2016; Manchanda, 2013; Shonkoff & Richter, 2009; Stagner & Lansing, 2009). The critical role that social factors play in determining health and wellbeing outcomes is now well understood (Braveman et al, 2011; The Marmot Review, 2010), and it has become increasingly apparent that too little attention has been given to the 'upstream' social determinants of health, such as economic resources, education, and racial discrimination (Braveman et al., 2011).

However, the current system of intervention and support services in developed countries such as Australia is predominantly geared towards crisis management rather than seeking to address the underlying causes that lead to families having problems in the first place (O'Connell et al., 2009; Maziak et al., 2008). For instance, while poverty is a key risk factor for child maltreatment, it is rarely addressed by child maltreatment prevention and intervention programs (Boivin & Hertzman, 2012). Direct interventions to address complex problems such as child abuse and family violence will always struggle to achieve sustainable results while the conditions that led to the problem remain unchanged (Braveman et al., 2011; Moore & McDonald, 2013; Stagner & Lansing, 2009).

An alternative to direct intervention is an approach that seeks to address the underlying causes of problems and is known as 'pre-prevention' or 'true prevention' (O'Connell et al.,2009; Maziak et al., 2007; Stagner & Lansing, 2009), or the public health approach (Barlow & Calam, 2010; Mistry et al., 2012). These approaches differ both from direct interventions - which address the presenting problems or symptoms - as well as promotion approaches - which seek to actively promote positive health or behavioural practices. The pre-prevention approach seeks to transcend the traditional 'silos' within which services traditionally operate by establishing systems of collaboration that address long-term underlying problems and thereby prevent future ones (Stagner & Lansing, 2009). Barlow and Calam (2010) argue that 'a public health approach to safeguarding is the only way of ensuring that all children are protected within a population, including children at high risk.'

[3] This evidence summary is based on Moore and McDonald (2013).

While the logic of such an approach is powerful, it is not possible to demonstrate that promoting positive conditions for all families *directly* reduces the occurrence of child maltreatment or neglect. That is because the causal chain between optimal conditions and child maltreatment is too long, containing too many intervening links. However, the evidence does indicate that the social and physical environmental conditions in which families are raising children have a significant effect upon parental functioning and parenting. When the conditions are positive, then families are more likely to function well and there is a decreased risk of parenting problems, including maltreatment and neglect. Thus, the relationship between family environmental conditions and child maltreatment is indirect, and many factors can intervene between the provision of positive conditions and ultimate child maltreatment outcomes.

Issues and implications

One of the key issues raised by this evidence is the need to shift to a more prevention focused approach. Over time, successful prevention efforts will result in a reduced demand for secondary and tertiary services. However, the secondary and tertiary services that government support are already fully stretched and arguably underfunded, so would seem to have little capacity to add other roles to their workload. The solution to this dilemma lies in a combination of two strategies. First, freeing up some of the time devoted to secondary and tertiary services and seeking to drive the expertise downwards to strengthen the capacity of the universal system to meet the needs of all families. Second, funding new prevention initiatives (eg. outreach services to find and engage families not involved in services and / or social networks).

Action at this level goes well beyond what a single government department such as DHHS can do, and necessarily involves multiple sectors and levels of government, as well as non-government services (CCCH, 2007, 2009; Moore & Skinner, 2010; Trickett et al., 2011). As Trickett and colleagues (2011) have argued, ‘A scientific paradigm is emerging that supports collaborative, multilevel, culturally situated community interventions aimed at creating sustainable community-level impact’ (p. 1410).

The evidence indicates that interventions implemented through the combined efforts of health, nutrition, education, and social protection sectors are effective at improving early child development (Daelmans et al., 2015). To be fully effective, action at this level also needs to involve sectors responsible for the local economic, physical and social infrastructure, including employment opportunities, public transport and connectivity, and the design of residential communities (VicHealth, 2016). Crucially, such efforts need to engage communities as meaningful partners in determining what goals are being sought and what strategies are to be used to achieve them (Moore et al., 2016). Involving communities in the co-design or co-production of services is another critical element (Bradwell & Marr, 2008; Boxelaar et al., 2006; Boyle et al., 2010; Hopkins & Meredyth, 2008; McShane, 2010; Needham & Carr, 2009).

Place-based (or collective impact) approaches offer one way of doing this (CCCH, 2011; Moore, 2014; Moore et al., 2014; Moore & Fry, 2011; Moore et al., 2016). These involve stakeholders engaging in a collaborative process to address issues as they are experienced within a geographic space, such as a neighbourhood, a region, or an ecosystem (Bellefontaine & Wisener, 2011). These approaches are designed specifically for geographical areas that are experiencing many challenges, and are not needed in all localities. For an overview and examples of place-based initiatives in Australia, see Fry et al. (2014) and Laidlaw et al. (2014a, 2014b).

Providing services for all families

Universal or primary level services are provided to all families in a population. These services are aimed at preventing the occurrence of problems in the first instance by offering supports and interventions routinely to all members of a population (Axford & Barlow, 2013). The key features of universal services is that they are seen as being a 'social good' for everyone, and they can be used to promote well-being (i.e. promotion above) and also to prevent problems by identifying families in need of additional services (Axford & Barlow, 2013). Universal services may also take the form of promotion activities and interventions that are delivered to everyone within a particular population and involve the use of both individual methods of working (e.g. advice from practitioners to individual families) alongside the use of media-based methods that can be delivered both to individual families and the wider population (e.g. public health campaigns) (Axford & Barlow, 2013).

Rationale and evidence

There are several grounds for investing in universal services.

First, there is the evidence that experiences in the womb and infancy (the first 1000 days of life) can have lifelong consequences for health and wellbeing (Centre on the Developing Child at Harvard University, 2010; Gluckman et al., 2010; Heindel, 2007; Moore, 2014; Moore et al., 2015b; National Scientific Council on the Developing Child, 2010, 2012; Prescott, 2015). This is because they occur when the fetus / infant is at its most vulnerable neurologically and developmentally (National Scientific Council on the Developing Child, 2005, 2010, 2012; Norman et al., 2012; Shonkoff et al., 2012; Teicher & Samson, 2016). Maltreatment and neglect that occur in the first 1000 days are particularly damaging, resulting in complex trauma (Cook et al., 2005; van der Kolk, 2005). This profoundly disrupts developmental pathways, with lasting effects on the person's health, well-being, relationships and parenting, and is the most difficult form of trauma to treat.

Second, there is strong evidence that intervening early is more cost effective than intervening later (Cunha et al., 2010: Heckman, 2013; Moore & McDonald, 2013). These economic analyses have shown that the younger the age group receiving support through targeted programs, the higher the rate of return, with the highest rate of return from interventions occurring between 0-3 years of age.

Third, there are good grounds for basing service systems on a strong universal platform (CCCH, 2006; Mantoura & Morrison, 2016). There is a great deal of evidence (e.g. Goldfeld & West, 2014; Marmot, 2015; Moore et al., 2015a, 2015b) to show that the development, health and well-being of children is shaped by social determinants, resulting in inequities in outcomes that follow social gradients: while the greatest concentrations of poor outcomes are among the lowest socioeconomic populations, such outcomes are evident across the whole population (albeit in progressively decreasing concentrations), and the majority of cases overall are found at levels other than the lowest socioeconomic one.

How can these social inequalities be reduced? Mantoura and Morrison (2016) identify three ways: by focusing only on improving outcomes among the most disadvantaged groups, by reducing the gap between the most disadvantaged and other groups, and by addressing inequalities across the population. Interventions targeting the most disadvantaged may look appealing, but have several disadvantages, including the risk of stigmatising the targeted populations (Solar & Irwin, 2010), and of neglecting those who live in disadvantaged circumstances or come from disadvantaged backgrounds but do not live in areas targeted (Newman et al., 2015). Based on their analysis of the evidence, Mantoura and Morrison (2016) conclude that improving outcomes for disadvantaged groups and narrowing gaps are necessary but not sufficient objectives: reducing inequalities in outcomes ultimately

requires a social gradients approach. This is what a service system based on a strong universal platform and progressive universalism is designed to do.[4]

However, as in the case of the first service level discussed, it is not possible to demonstrate that any of the various forms of universal services and support *directly* reduces the occurrence of child abuse or neglect. That is because the causal chain between optimal conditions and child maltreatment is too long, containing too many intervening links. However, while it is unclear whether these strategies actually prevent psychological maltreatment, there is preliminary evidence to suggest that the use of population strategies of this nature show promise in the prevention of child maltreatment generally (Hibberd et al., 2012).

Issues and implications

There are a number of issues to be addressed in designing and delivering a core set of services for all families.

First, for families of children under school-age, providing universal services is problematic because not all families are consistently engaged with the service system. Families can be isolated and marginalised for various reasons (CCCH, 2010). Finding ways of reaching and engaging these families is a major systemic issue, requiring the development of more assertive outreach strategies to find and engage families not involved with the available or services or with local social networks.

Second, providing universal services involves more than providing a range of services, but also ensuring that services are accessible to and inclusive of all families. An important issue is how to strengthen the capacity of universal services to meet the basic needs of all children and families, regardless of needs, abilities and background. Specialist services (health, mental health, disability etc.) can play a role by supporting mainstream services in catering more effectively for the diversity of children and families.

Third, there are the particular challenges in meeting the needs of Aboriginal and CALD populations. In working with Aboriginal populations, the evidence suggests that it is the evidence-based processes identified in this review that play a particularly important role: building trust and establishing relationships are critical, as is gaining the support and engagement of local leaders before programs are introduced (Bowes & Grace, 2014). Programs are more likely to be effective if they are strengths-based and family-centred, flexible and sustainable, and adapted to suit the local needs and context (Bowes & Grace, 2014).

Fourth, there is the issue of how to involve fathers in services (Fletcher, 2013). While fathers often attend antenatal classes, it is mothers who usually attend MCH visits and activities such as story time at the library. Nevertheless, many fathers are taking a more active role in their children's lives and care. Consequently practitioners need to be more aware of and attentive to engaging fathers when working with the family. Father-inclusive casework practice may not be appropriate or may need to be approached differently in some situations, such as where there is marital conflict, when the mother does not want the father involved with the program, or where there is domestic violence in the family (NSW Department of Community Services, 2009).

[4] It should be noted that this depends upon the universal system being able to engage all families – yet we know that the families experiencing most vulnerabilities are those least likely to use universal services. Ways of finding and engaging such families need to be developed.

Finally, there is a fundamental question about what forms of service should be available to all families? Is the current range of services sufficient? The current system does not consistently provide places and opportunities for families to meet and form the support networks that are so beneficial.

Providing additional support to families facing extra challenges

Secondary or targeted interventions are those delivered to families where there are early signs of problems that, if not addressed, may pose significant difficulties in terms of the family's capacity to care for and protect their child (Axford & Barlow, 2013). This level involves providing additional support to families who are facing additional challenges, with the aim of helping them manage the challenges more effectively and reducing the number of families who go on to experience significant problems.

Rationale and evidence

The number of families experiencing multiple challenges appears to have increased in recent years. As Bromfield et al. (2010) have noted:

> Families with multiple and complex problems are no longer a marginal group in service delivery. In fact, they have become the primary client group of modern child protection services. The challenge for child protection services is to respond holistically to address inter-related problems, in order to better support families to make and sustain changes to better meet the needs of children.

The extra challenges that families face may take different forms (Ghate and Hazel, 2002, 2004; Jack and Gill, 2003; Landy and Menna, 2006; and Slee, 2006): factors within the child, factors within the parent(s), factors within the family, and factors in the wider community and society.[5]

- *Factors within the child* may include chronic health issues, behavioural and mental health problems (e.g. attention deficit and hyperactivity disorder), and developmental disabilities.
- *Factors within the parent or parents* may include low levels of education, parental mental illness, parental chronic medical condition, parental intellectual disability, parental criminal record, alcohol and drug abuse, recent life stresses (death, job loss, and immigration), language barriers, and a parental background of severe abuse, neglect, or loss in childhood that is unresolved.
- *Factors within the family* include single teenage parent, low income / food insecurity, chronic unemployment, insecure or inadequate housing, frequent moves, severe family dysfunction and/or instability and family violence.
- *Factors within the wider community* include lack of social support / isolation, neighbourhood problems and community violence, lack of public transport, difficulties in accessing child and family services, non-family friendly urban environment, and lack of family-friendly and culturally safe recreational and other facilities.

[5] The following section is based on an evidence paper prepared for the Department of Human Services by CCCH (Moore & Sanjeevan, 2011).

The key point regarding the factors that make families vulnerable is that the ability of parents to care for their children can be undermined by a whole range of parental, familial and social factors (Ghate and Hazel, 2002, 2004; Jack and Gill, 2003; Landy and Menna, 2006; and Slee, 2006). The evidence indicates that if these are not addressed, efforts to help parents with the problems they experience as a result of these factors are likely to be only partially effective or short-lived.

There are many risk and causal factors for problems such as child maltreatment. Although the prevention field now recognizes the interdependence of multiple causes of child maltreatment, many interventions focus on addressing one particular risk factor. The result is a wide range of disconnected and under-funded prevention activities.

What is clear is that the capacity of parents to raise their children in ways that they (and we) would wish is compromised by factors beyond their control. Parents do not set out to do a poor job of raising their children, but some end up doing so because of external factors beyond their control. For many of them, these externalities – housing, finances, family violence etc. – are more salient and more stressful than the immediate care and parenting needs of their children (Carbone et al., 2004). A major focus of work with parents, therefore, is to seek to remove (or at least manage and stabilise) these barriers to family functioning and parenting.

Another way of thinking about these issues is in terms of *foreground* and *background* factors and services.

- *Foreground factors* in people's lives are the problems they present with – e.g. with parenting and care of children. These are the problems that are most salient to professionals. Foreground services are those that address these problems and seek to remedy them directly. These include universal services (MCH etc.), secondary / targeted services (EMCH), and tertiary / treatment services.
- *Background factors* are the underlying causes of the foreground / presenting problems and may either be internal (personal factors in the parent) or external (circumstances in which families are living) or a combination of both. Background services are those that seek to address specific background factors – e.g. housing, family violence, drug and alcohol use.

The evidence indicates that, if these background factors are not addressed, then the impact of direct foreground services is weakened – either they do not work at all (because the parent is too preoccupied with other issues) or they are effective in the short term only. Families experiencing vulnerabilities are those with background factors that are likely to compromise their parenting, and direct efforts to help them with their parenting struggle to make a lasting positive difference as a result. For these services to be effective, the background factors that are resulting in the parenting problems (and that will continue to undermine any direct efforts to improve parenting) need to be addressed directly.

Issues and implications

A major issue at this level of service is how to identifying and engaging families who need additional support.[6] As Barlow and McMillan (2010) observe, parenting follows a normal distribution – there is no 'natural' cut-off between abusive and non-abusive, and society has to decide where the threshold should be, with many factors influencing the decisions that practitioners have to make on an individual basis. The usual approach has been a risk-based approach in which families are targeted for additional support on the basis of a series of risk factors that are known to be associated with a high likelihood of having problems in parenting (e.g. teenage parent, family violence etc.). In this approach, the need for additional support is identified by the professionals rather than the families themselves.

There are a number of problems with this approach. First, not all families who fall into particular risk categories will experience problems, and therefore do not need additional support. For instance, risk assessment tools used as predictors of maltreatment identify many families who will not maltreat their children and fail to identify some who will go on to seriously abuse them (Munro 2000; Baird and Wagner 2000).

Another problem is that it can be difficult to 'sell' targeted programs to families who have not asked for them and may view them as stigmatising. Furthermore, the risk-based approach defines families experiencing vulnerabilities in terms of external features (risk categories) and therefore tends to view vulnerability as a property of particular people or groups. This can lead to services viewing families experiencing vulnerabilities negatively, regarding parents as irresponsible or families as dysfunctional (e.g. if they fail to keep appointments).

Additionally, it is not uncommon for CALD and Aboriginal families to have negative perceptions of institutional services. For example, many newly arrived refugee families are survivors of torture and trauma and can associate institutional services with their trauma. Furthermore, the concept of professional service delivery where a perceived stranger provides advice on child rearing or family violence can be uncommon or 'un-natural' in some CALD communities where such things are often only dealt with in the confinement of the family or community setting.

In contrast to the risk-based approach are needs-based or response-based approaches. These identify children and families needing additional support on the basis of their expressed needs or concerns. This approach makes use of family-centred tools such as the Parent Evaluation of Developmental Status (PEDS) (Glascoe, 1997, 1998) and the Parent Engagement Resource (Moore et al., 2012) to identify parental concerns about their children and family.

There are a number of advantages to this approach. First, it is more efficient in that it delivers services to those who have actual rather than possible needs. Second, because the services are being delivered in response to concerns that families have identified, there is a greater chance that the parents will accept and make use of the services. However, despite the advantages of the needs-based approach to working with families experiencing vulnerabilities, there are some major challenges to be faced in implementation. One major challenge is to ensure the service system as a whole is able to engage families in such a way that their concerns and needs can be promptly identified and responded to.

[6] This section is based on an evidence paper prepared for the Department of Human Services by CCCH (Moore & Sanjeevan, 2011).

Another challenge is how to equip front-line practitioners with the skills and tools to engage parents in discussions about their children's needs, and how to identify signs of children who are experiencing maltreatment and neglect. The experience of multiple, chronic and prolonged adverse experiences in early childhood results in complex trauma, which differs from and is more damaging than the adverse experiences that produce post-traumatic stress disorder in adults (Cook et al., 2005; van der Kolk, 2005). To identify children in this situation, an approach called trauma-informed care has been developed. This is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage (Wall et al., 2016). Models of creating a supportive trauma-informed culture for children in early childhood settings are being developed (Holmes et al., 2015).

Another major issue, related to the issue of identification just discussed, is how to construct a system based on *progressive* or *proportionate universalism* (Barlow et al., 2010; Boivin & Hertzman, 2012; Feinstein et al., 2008; Human Early Learning Partnership, 2011; Marmot Review, 2010; Statham & Smith, 2010). This is an approach acl and is a service-based response to address inequities. One of the main reasons for basing this system on a universal service base rather than a targeted service base is the evidence of social gradients – child and family vulnerability exists in every socio-economic strata of our society, and is not exclusive to the most disadvantaged (McLean et al., 2014; Moore, 2008; Oberklaid et al., 2012). Although most highly concentrated in the lowest socioeconomic strata, child vulnerability exists across all socioeconomic levels of society. Concentrating services on the most disadvantaged groups – or on highly disadvantaged areas – will miss many children who need support and will provide services to some families who do not need them (Moore & McDonald, 2013).

There are some major challenges to be overcome in constructing a system based on progressive universalism. Reaching all children in our community requires tailoring our strategies to reach children in all walks of life and addressing the barriers to access that some experience (Human Early Learning Partnership, 2011). An important objective is to identify those with greatest need at the earliest possible opportunity and to provide appropriate support (Feinstein et al., 2008). This is a challenge since we do not have tools for this purpose. There is also the problem that the families experiencing the most vulnerabilities do not engage with universal services, and more assertive outreach strategies are needed to find these families and work with them to design settings and services that they will use.

The current service system bears some resemblance to a progressive universalism system in that it includes universal, secondary and tertiary services, but these are not linked to one another in a systematic way (CCCH, 2006). Typically, referral for additional support involves the child or parent receiving a more intensive service in a separate location from specialist providers, where they may be required to describe their experience again due to poor communication between services, adding to their trauma. There may be little or no subsequent contact with the mainstream provider who made the referral, and who therefore learns nothing about how they could have helped (or even were already helping the person). In the progressive universalism model, the identified child or parent would continue to attend the mainstream service, with additional support provided to the person *and* to the service provider. Expertise is driven downwards – the specialist seeks to build the capacity of the mainstream service to meet the basic needs of the child / parent / family.

Another major issue concerns the need to build an integrated system of services that is capable of responding promptly to emerging child and family needs (Bromfield et al., 2010). Practitioners need to

develop networks built on trust and mutual aims in order to ensure that children can access all the services they require when they require them (Daniel et al., 2010).

Providing specific support for families at risk of child maltreatment

Secondary or targeted interventions are those delivered to families where there are early signs of problems that, if not addressed, may pose significant difficulties in terms of the family's capacity to care for and protect their child (Axford & Barlow, 2013). This level involves providing additional support to families who are experiencing difficulties caring for and protecting their children. The aim is to reduce the number of families who go on to have statutory involvement with child protection.

Rationale and evidence

According to Barlow and Scott (2010), over the last ten years, policies governing the response to maltreatment in the UK have moved from a 'child protection' model, towards a 'child and family welfare' approach to safeguarding. This involves a focus on the identification of children in need and the provision of much earlier support and services, in contrast to the identification and investigation of maltreatment, and the assessment of future risk. International comparisons have shown that countries adopting child and family-welfare focused systems achieve better outcomes (Katz and Hetherington 2006). According to Gilbert et al. (2009), policies emphasising substantiation of maltreatment without concomitant attention to welfare needs lead to less service provision for maltreated children than do those in systems for which child maltreatment is part of a broad child and family welfare response.

A child and family-welfare approach depends upon practitioners engaging and building strong relationships with families. However, as Thoburn et al. (2009) note:

> many parents, as well as children and young people who suffer from neglect and maltreatment, mistrust formal services. This puts children and young people at risk of further significant harm. It is therefore necessary that parents and children feel that they are not stigmatised when seeking help and that they retain an appropriate degree of control over subsequent stages of the support and protection process. (p. 1)

Gaining the cooperation of complex families requires services to be dependable and professional, and is likely to require a long-term relationship with the service providers. Apart from the consistent conclusion about the centrality of the professional relationship, no one service approach or method has yet been robustly evaluated as effective with complex families where there is evidence of maltreatment, or where maltreatment is likely unless effective services are provided (Thoburn et al., 2009).

Issues and implications

Again, there is the challenge of identifying those families at risk of child maltreatment. The adequacy or otherwise of one's parenting is a highly sensitive issue for most parents, even more so for families facing multiple challenges. For practitioners to be able to engage such families in open discussion about their parenting challenges requires particular relationship skills and tools. A response-based or needs-based approach (where support is provided to families reporting concerns about parenting or family functioning) is more likely to lead to such discussions than a risk-based approach (where support is provided to families whom professionals deem to be at risk of having problems in providing their children with adequate care and parenting).

Providing support to families receiving statutory child protection services

For families involved with statutory child protections services, tertiary or treatment interventions are provided with the aim of reducing the negative impact of the particular problem being targeted and preventing its re-occurrence (Axford & Barlow, 2013; Barlow & McMillan, 2010). In the case of families receiving statutory child protection services, the aim is to ameliorate the impact of neglect or maltreatment on the child and prevent the re-occurrence of the neglect or abuse. Services at this level can focus on the child, the parent-child relationship, or the family as a whole (Barlow & McMillan, 2010).

Rationale and evidence

According to Barlow and Scott (2010), parents who provide parenting that is harmful in terms of their child's development have mostly been exposed to early environments that did not meet their own developmental needs or that were characterised by trauma. This compromises their ability to respond to their children's demands or manage their children's fears.

What such parents need is what Barlow and Scott (2010) call an 'emotionally corrective relationship' that consists of two basic features:

- a supportive therapeutic stance based on principles of acceptance, empathy, genuineness and trust, all of which are essential to fostering a strong alliance between client and worker and to meeting some of the parent's unmet developmental needs, particularly that of containment, and
- a focus on interpersonal and relational issues with the aim of giving parents an opportunity to reflect on the parenting they are providing in the light of their own experiences of being parented, alongside the opportunity to increase their capacity for some of the key aspects of parenting.

The provision of such relationships is potentially an extremely effective method of working with parents who struggle to meet their child's developmental and safety needs. This is because, in addition to taking account of the systemic factors involved, this approach targets the key developmental processes that are now recognised to have shaped the parent's capacity for emotional regulation, and thereby their capacity for establishing secure, loving and trusting relationships (Barlow & Scott, 2010).

Issues and implications

Providing such a relationship can be a highly demanding task for practitioners. Their own ability to care for their clients in this demanding way and to sustain that commitment over time depends upon being supported through receiving adequate and regular professional development training, and support by their managers, supervisors, colleagues and partners (Moore, 2006). Programs are unlikely to work if caseloads exceed a practitioner's capacity to meet the needs of families, including the need to take time to build trusting relationships. Programs are also unlikely to be sustainable if practitioners are not provided the level of support required to avoid burnout and high rates of staff turnover.

Providing support services to children living in out-of-home care

This is a tertiary or treatment level of service. The aim is to reduce the impact of their adverse experiences on children, and to support the development of positive attachments in their new environment.

Rationale and evidence

Before they come into care, children and young people's relationships are often fractured, chaotic, frightening, violent and abusive, and being in care provides them with opportunities to experience loving, secure, stable and safe relationships. While children in care value these opportunities, they experience difficulties in building and maintaining positive and meaningful relationships (Winter, 2015).

Issues and implications

While there are a number of effective programs for this target group, many of the most effective ones are resource intensive. This has significant implications for caseloads, professional support, service system capacity, and appropriately matching clients with practitioners. The less intensive programs tend to have weaker evidence (e.g. *Life Stories* compared with *Treatment Foster Care*) or do not appear to have been rigorously tested with this group of children specifically (e.g. *Tuning Into Kids*). Some of the less intensive programs rely on paraprofessionals (e.g. *Life Story Intervention*) or community members (e.g. *Big Brothers, Big Sisters*). There needs to be consideration for how those involved can be trained and supported in these roles.

There are also unique challenges faced by young people who are considered 'difficult to place' due to behavioural issues or who require additional support. In this instance the young person is likely to be placed in a residential care setting where rotating staff provide supervision and the young person is not provided with the opportunity to form a stable and long-lasting relationship with any one caregiver.

The issue of cultural safety is of particular significance to Aboriginal and CALD children who come into care. While efforts are made to place the child with a family member or member of the community, in order to preserve the child's connection with their cultural heritage, this opportunity is not always possible, Aboriginal children are almost five times more likely to be placed in care compared to their non-Indigenous counterparts (Australian Institute of Health and Welfare, 2007). However there is significant shortage of culturally appropriate placements for Aboriginal children in care.

Additionally, the ongoing reality of multiple placement changes has significant adverse effects on children and young people in care. A number of studies have found existing correlations between continued instability in placements and adverse psychosocial outcomes, such as emotional difficulties, behaviour problems and poor academic performance (Rubin et al. 2007).

There are also existing issues around providing adequate support to foster, kinship, and informal carers. These can include supports such as adequate training on caring for a child who has experienced trauma, crisis response training, providing respite and ensuring that the carer is receiving adequate financial and emotional support. Carers play a central role in providing better outcomes for child in care and as such must be viewed as entitled to support services in their own right.

The issue of abuse in care is ever-present. This includes abuse in residential care as well as foster, kinship, and informal care. Issues relating to this matter include lack of adequate training for carers (residential and foster) on how to recognise and respond to physical/sexual abuse and 'grooming' appropriately. Moreover, in Victoria the agency responsible for case-managing a child in foster care is also responsible for regulation of matters such as abuse in care. This is a conflict of interest. Organisational practices in responding to and preventing abuse in care are not homogenous across Victoria and are not founded on evidence-based practices.

Providing support to carers

Carers, whether they be permanent, kinship or volunteer, play an integral role in the daily and future life experiences of children or young people who come into out-of-home care. Ensuring that existing policies and frameworks reflect this reality and facilitate the retention, expansion and support of carers is central to ensuring positive outcomes for children and young people in care.

Rational and evidence

Evidence suggests that the positive experiences of children and young people in care can play a significant role in how well they recover from their experience of trauma and access positive opportunities later in life (Higgins, 2011). However, with the increase in the number of children coming into care, and a simultaneous increase in the number of carers leaving the system, demand is fast outgrowing supply.

Issues and implications

Primary issues surround the recruitment of new carers, retention of existing carers, and the increase in the number of children with complex and co-occurring needs coming into care. Several studies have found that the fastest growing group of foster children and young children have high rates of 'medical illnesses, developmental delays and substantial risks for psycho-pathology,' requiring extensive support (Clyman et al., 2002; Robertson, 2005).

These may in turn result in additional problems relating to the service's capacity to appropriately match the unique needs of each child with the right foster carer, and increase the likelihood of multiple and broken placements. This can have adverse effects on the child's long-term life opportunities through disrupted access to education and a lack of opportunity to form lasting relationships with a caregiver. Moreover, it may also act as a deterrent for the carer to continue in their role, given their potentially negative experience of the system.

There has been ongoing conversations regarding the professional role of foster parents in recent years. This is because the role of carers has continuously evolved from everyday parenting to one where it is not uncommon for them to be dealing with complex issues requiring regulation, supervision and training (Wilson & Evetts, 2006). Carers who are provided with high quality training and are well resourced have been shown to develop skills, knowledge and confidence in their caring role which ultimately means better outcomes for the children in their care (Higgins & Butler, 2007).

Providing support to care leavers

This is another tertiary or treatment level form of service. The aim is to ensure care leavers make a successful transition to independent living. This includes mastering a series of independent living skills that they may not have had responsibility for previously, such as housing, employment, education, health behaviours, supportive relationships etc.

Rationale and evidence

The transition from care is a particularly vulnerable time for many young people in care and ensuring they have supportive relationships during this time is critical for young people in helping them manage the demands of this experience (Hannon et al., 2010; Winter, 2015). A recent Scottish initiative has even explored maintaining ongoing relationships between practitioners and young people after they had left care (Daly & Rice, 2016).

Issues and implications

There are few evidence-based programs or strategies at this level. The following are the Research questions to be addressed.

- What services/programs are available to adolescents and young adults transitioning to independent living (whether in out-of-home care or from homes where maltreatment has been an issue)?
- What services/programs are available to young people who have had contact with the juvenile justice system?
- Which programs are effective?
- Which outcomes relevant to a successful transition (housing, employment, education, social support, health and wellbeing) can be addressed by available programs? How are those who would benefit from such programs identified?
- What outcomes are important to them? (housing, employment, education, social support, health and wellbeing).
- How can those programs not currently rigorously evaluated be supported to undergo evaluation?
- What strategies can be used to integrate services covering the different outcome areas relevant to the transition?
- How do existing policies, practices and legislation for young people leaving care reflect evidence pertaining to best practice and to what extent is it informed by what young people have identified as being important to them?

An inherent problem of the research in this area is that legislation differs in each jurisdiction, so that the findings from a study conducted in one jurisdiction cannot be generalised to another. There is currently no uniform leaving care standards across jurisdictions in Australia and although legislation supports the provision of additional support to care leavers until the age of 21, the system is fragmented at best and does not always facilitate continuity of relationships between care leavers and support staff.

Additional challenges can occur when leaving care practices are not consistently embedded in the young person's care experience and are only considered when the young person is close to leaving care.

Research also suggests that Aboriginal youth face specific challenges when leaving care. For example, Aboriginal young people who have left care are more likely to have involvement with the youth justice system than their non-Aboriginal counterparts (Indig et al., 2011; Kenny & Nelson, 2008).

Implementing evidence-informed practice: preparing the workforce

Aboriginal populations

There is a significant shortage of evidence-based programs specifically tailored to Aboriginal groups, and the present review found none that met the standards for inclusion in the menu of evidence-based programs.

However, there is some evidence regarding effective ways of implementing programs. What this evidence tells us is that implementing programs with Aboriginal groups requires particular care. A recent review of the effectiveness of implementation in Aboriginal Australian health care (McCalman et al., 2016) found that many new programs lacked adequate evidence of efficacy, and needed to be rigorously evaluated to show that they were producing positive outcomes. In addition, further research was required to explore Aboriginal people's understanding, principles and knowledge of what is important in healthcare implementation, particularly in relation to the value of community control and equity issues. One of the key conclusions was that important preconditions for the effective implementation of programs were enabling Aboriginal leadership, governance and involvement in implementation and tailoring services and programs to local needs (McCalman et al., 2016).

Another recent study focused on the factors that enable Aboriginal organisations to create positive change in their communities (Hunt, 2016). Common themes underlying their approaches with their communities included:

- building on strengths, and giving people the skills, responsibilities and confidence to take on new tasks and new roles
- doing this with the right supports in place to mentor and train in very practical ways, often on the job, and to encourage people to develop themselves
- working holistically to help resolve the many challenges individuals face in being able to have a job and progress in their employment
- supporting people to have a voice in decisions affecting them, and enabling that voice to have influence through their organisation
- ensuring that Aboriginal people can take control, and determine priorities that meet their aspirations and needs
- doing all this within a cultural framework relevant to the location, especially (but not exclusively) in more remote communities, with staff who are highly capable interculturally (Hunt, 2016).

The conclusions from these two studies consistent with the findings of the present review regarding evidence-based processes and evidence-informed decision-making.

Little research has considered frameworks for supporting the direct participation of Aboriginal people in child protection decisions. As it stands, 'participation' is primarily based on a service model that functions to either provide cultural advice or support from independent Aboriginal community-controlled organisations in child protection processes. However, the extent to which Aboriginal people currently participate in key decisions throughout all phases of child protection intervention is unknown. Here we refer to a definition of participation that goes beyond consultation to include a wide range of active participation in decision-making processes, requiring a change in power-dynamics whereby one party with control over decisions surrenders authority and allows influence of others (Secretariat of National Aboriginal and Islander Child Care, 2013).

This real way of participation is based on the acknowledgment that the cultural values that underpin public institutions and frameworks have for the most part been created in the absence of equal participation by Aboriginal people. Participation on equal terms must allow for systems cultural change and not merely adding Aboriginal peoples to existing mainstream processes (Libesman, 2007). Studies continue to point to the positive correlation between participation in quality early intervention programs and notably improved lifelong outcomes, particularly for vulnerable and disadvantaged children, including Aboriginal children. However, improving access to these services remains a challenge for mainstream providers who may not have the required structures to facilitate increased access and participation. One key way to improve Aboriginal families' engagement with early intervention programs is to improve the services ability to 'be culturally safe in their practice and service delivery. A key component of cultural safety rests on employing Aboriginal staff.

The limited data available on Aboriginal-focused early childhood and care services, including their workforce, makes it hard to develop a comprehensive understanding of the current state of affairs, and reduces governments' ability to effectively deliver quality (culturally appropriate) services.

CALD populations

Similar to Aboriginal groups, there is a significant shortage of evidence-based programs specifically tailored to CALD groups. Our review only identified two programs for CALD groups that met inclusion criteria, and neither has demonstrated effectiveness with an RCT evaluation.

Other research indicates that humanitarian migrant families face higher risk of having statutory child protection involvement (Losoncz, 2015). Greater understanding into the causes of intergenerational conflict in CALD families and how child protection and other support services can engage and intervene more effectively with these families is needed. Furthermore, while the relevance of responsive regulation has been established among other communities, its role in refugee communities and how it can support families in transforming parenting practices to align with the cultural and legal requirements of their new country is less understood. Appropriate staff cultural training and the ability to appropriately engage external supports such as interpreters and community members is central to ensuring positive outcomes for children and families.

Engaging CALD families can be challenging as some may have misconceptions regarding the role of institutionalised services, due to their negative experiences of authorities in their home country. There is also limited data relating to the appropriate use of interpreters and how this can impact the family. For

example, culturally homogenous interpreters do not always offer an assumed empathy and understanding to the family. This can be due to cultural and social hierarchies such as caste systems, religions differences, or different ethnicities within the one jurisdiction. Additionally, interpreters can sometimes be members of the community, known to the client. This poses a significant conflict of interest where the interpreter may share information with community members or the client does not feel comfortable to share personal information given a perceived fear that the interpreter may share that information with others in the community. Gender matching the interpreter with the client may also be required due to cultural norms or in situations of domestic violence or sexual abuse.

Training

An evidence-based system is dependent upon the front-line practitioners who work directly with clients and client groups. To deliver evidence-based services, these practitioners need training (in their original courses) as well as in ongoing professional development) in three areas.

- *Evidence-based processes* – the core skills of engaging and building therapeutic relationships with parents, and partnerships with them.
- *Evidence-informed decision-making* – the skills involved in working with clients and client groups to agree on goals and identify strategies to achieve these goals.
- *Evidence-based programs* – the knowledge and skills to select appropriate programs for particular purposes, implement them with fidelity, and monitor their success.

Enabling and supporting high quality relationships between professionals and children and young people can be achieved but sometimes requires changes in services, teams and processes, as well as at the level of the individual professional (Winter, 2005). Mentoring in the early stages of learning is critical.

Supervision and mentoring

Working with complex families is very demanding, and practitioners need both supervision and peer support to enable them to build and sustain therapeutic relationships with parents. Just as parents need to be cared for if they are to be able to care for their children, so practitioners need to be cared for by managers and colleagues in order to be able to support the parents they work with. Services need to create the time and the culture that allows such support to be provided. Practitioners also need guidance in understanding and managing the challenges they face with different families.

A supervision model that combines the dual need for care and guidance and is therefore particularly well suited for those who work with families experiencing vulnerabilities is *relationship-based reflective supervision* (Heller & Gilkerson, 2009). The value of this approach is well-established, both for human services generally (Geller et al., 2010; Watson & Gatti, 2012; Weatherston et al., 2010), and welfare services in particular (Rauktis and Thomas, 2013).

Implementing evidence-informed practice: improving the menu of evidence-based programs

Due to limited time available for this project, the review of evidence-based programs used a rapid review approach. This meant that there are certain limitations to the findings that should be noted. Within the time-frame allowed for the current project, it was not possible for researchers to look very closely at the bodies of work supporting each program. The overviews of programs presented in the menu were constructed largely from summary information provided in reputable evidence databases, rather than from close examination of original research papers detailing the strengths and limitations of each program (and its evaluation). Without a detailed and comprehensive knowledge of the programs, it is difficult to make specific recommendations as to which programs would be best suited to the many different groups comprising Victoria's families experiencing vulnerabilities.

We did not have time to look in detail at the following.

- *Program reach,* i.e. the characteristics of populations included in trials. We know that some programs have been trialled with, for example, parents experiencing financial hardship or substance abuse problems. However, we did not have time to check for more detailed information such as whether the sample of parents with substance abuse problems also included those from low as well as high SES backgrounds, differing cultural backgrounds, urban or rural settings, etc. Unfortunately, it is likely that many of the programs have been trialled with small samples only, and even those with larger samples may not have had sufficient numbers to examine results for specific sub-groups. This is a common limitation in the research literature which can only be addressed if sufficient funding is committed to conducting further empirical research.

- *Program uptake*. This can be difficult to determine for several reasons. The first is that there was insufficient time to search for this specifically. The second is that some trials strop recruiting participants when they reach the desired sample. In this case, dividing the sample by the number of those eligible would not reflect the proportion of those one would expect the program to reach. A third reason is that information about how many families might be eligible in a given area is not always known. A fourth reason is that this information is sometimes simply not reported.

- *Program retention and engagement*. We did not actively search for information concerning how well a program retained participants (e.g. proportion of sessions attended) or how well it engaged parents (e.g. measures of active participation and implementation of recommended strategies).

- *The cost-effectiveness and sustainability of individual programs*. Cost information was included where easily accessible, but for many programs there was insufficient time to thoroughly search for this information (in publications or from program developers). Where cost information was available the level of detail varied substantively. For some programs it was limited to the estimated costs of implementation. Other programs have included cost-benefit analyses and reported the expected monetary return on investment. Very little was sourced in terms of sustainability- some programs appear to have run successfully for many years (e.g. the Nurse Family Partnership). For most programs it is unclear whether they are sustainable (that is, would continue to be acceptable and utilised by the target populations in a given area).

- *Maintenance of effects*. Some of the program summaries include information about how long different effects persisted. However, there was not sufficient time to systematically search for this specific information.

- *Strength of individual RCTs* (i.e. we did not extract information about the following characteristics of each study: sample size, double-blinded design, independent observation as well as self-report measures, standardised psychometrically sound measures, intention to treat analysis, etc).

Recommendations

Evidence-informed decision-making

- The central role of professional-client relationships in the delivery of welfare services should be explicitly acknowledged, and supported through appropriate training, mentoring and supervision, and administrative and organisational arrangements.
- An evidence-informed decision-making framework should be developed in conjunction with practitioners and parents as a guide to all service delivery, whether with individual clients or groups.
- Evidence-based programs should only be deployed in the context of a partnership relationship between practitioners and clients that uses an evidence-informed decision-making process to agree upon goals and identify potential strategies. It is important that a commitment to ongoing review of this process has been made, as there is sometimes a need to circle back and repeat earlier steps as part of a process of refocusing.

Menu of evidence-based programs

- In the light of the limitations of the present review, a more detailed and comprehensive review of evidence-based programs should be undertaken.

- Implementation of evidence-based programs should occur with groups most similar to those with which they have been trialled (and for whom they have been designed). Very careful consideration should be given as to whether a program is likely to be useful to populations with which it has not yet been trialled, and if it is decided the program may be of use, then the implementation of it with this new group should be rigorously evaluated and the results of the trial(s) disseminated.

- Rigorous evaluation of programs as implemented in Victoria should be encouraged and supported so that government can determine whether the programs that (a) have worked elsewhere or (b) have been implemented without strong evidence, actually work for Victorian communities. Ideally, support for such evaluations would include capacity to run longitudinal investigations, with cost-benefit analyses.

- Reviews of this menu of evidence should be conducted with some regularity (perhaps updated every 5 years). This menu of evidence was compiled in 2016. Some programs that may be

effective will have been undergoing development and evaluation at the time of writing, and as results will not have been published, these programs will not have been included in the menu. Similarly, the strength of evidence supporting programs currently included in the menu may change. Some programs will develop a stronger research base while others may need to be removed or altered should future evaluations find they are not effective or have detrimental effects, particularly with the populations of most interest to Victorian practitioners.

- Consideration should be given as to whether the menu should be expanded to include other 'promising' programs. Owing in part to time restraints the menu was largely confined to programs with RCT level evidence. However, there are other valid forms of evidence worth considering. RCTs typically ask the question 'does this program work?', and rarely explore, in depth, for whom they work and how. Realist evaluations ask 'For whom does this work, when or under what conditions, and why/how?' In cases where RCTs are not possible for ethical or practical reasons, other forms of evidence should be considered. This may include qualitative as well as quantitative methods.

- Consideration should also be given as to whether programs targeting broader risk factors (e.g. parent mental health, substance abuse, domestic violence) should be included in the menu. Programs currently included may not be effective if broader contextual problems experienced by families with complex problems are not first addressed.

- Efforts to develop and evaluate programs for specific groups currently not serviced by any programs with a strong evidence base should be supported. The menu clearly shows gaps in the research literature for programs targeting CALD populations and young people transitioning from out-of-home care to independent living. Other potential gaps appear to include programs for children with disability (as opposed to emotional or behavioural problems), and programs with a focus on child health behaviours or education outcomes. Only a few of the programs examined outcomes in these areas, and were relatively restricted in terms of child age (e.g. education was considered for pre-schoolers and care-leavers; health behaviours were examined for adolescents). Without having conducted a review of the literature on the negative outcomes associated with child maltreatment, it is difficult to identify what other gaps there may be.

- Significant investment is needed in pre-prevention through the provision of acceptable and enriching living conditions for all families. The menu is characterised by a concentration of programs that have been developed for those already at risk of or experiencing child maltreatment, with some demonstrating a reduction in child abuse and neglect or a reduction in its potential. No program appears to prevent child maltreatment from ever occurring.

Levels of prevention

Providing positive conditions for all families

- Whole of government approaches to addressing the conditions under which families are raising young children should be explored. As well as the more obvious candidates such as the departments of human services, health and education, other departments should include housing, transport, urban planning and development, employment, and environment.

- It is essential that departments develop systems of collaboration that transcend the traditional 'silos' within which services traditionally operate in order to address long-term underlying problems and thereby prevent future ones.

- The focus of action at this level should be on building local economic, physical and social infrastructure, including employment opportunities, public transport and connectivity, and the design of residential communities (i.e., libraries, swimming pools, green spaces). Such efforts need to engage communities as meaningful partners in determining what local conditions need to be addressed, the goals being sought and what strategies are to be used to achieve them (Moore et al., 2016).

- Place-based approaches represent a key way in which the needs of localities experiencing complex challenges can be met. Support for such initiative should be provided, and ways in which government departments can be partners in such initiatives should be explored.

Providing services for all families

- Forms of outreach to find and engage isolated and marginalised families should be explored and trialled. (This is not exclusively a DHHS responsibility, but one that should be undertaken collectively on behalf of the whole service system.)

- Approaches that ensure services are accessible to and inclusive of all families should be identified and explored. In particular, investigating ways to strengthen the capacity of universal services to meet the basic needs of all children and families, regardless of needs, abilities and background is important. International examples may provide insights into how this may be achieved in Victoria and more broadly.

- Promoting positive parenting by making parenting programs for all families, and by using every contact between professional and parents as an opportunity to promote positive parenting and healthy relationships between parents and children. One way in which the latter can occur is through the manner in which practitioners relate to parents. Practitioners model for parents how to relate to their children by the way they relate to them. As such, training of front-line practitioners that provides them with skills and strategies to enable and support high quality relationships with parents is recommended.

- Explore ways of increasing the involvement of fathers in all decision-making and program delivery, including initiating changes to make services more accessible to fathers. Many of the methods for engaging fathers are the same as engaging other potentially 'hard to reach' groups in the community, and should be built on a strengths-based approach (Tehan & McDonald, 2010). It is important that service systems acknowledge men and their needs and preferences when considering engagement and service delivery methods. Examples of strategies include: flexible hours of operation, 'hands-on' learning opportunities, having a male staff member or male volunteers (especially 'front of house'), a program specifically for men, holding child and family activities in 'male friendly' spaces (e.g., sporting clubs, religious institutions). Further, building staff and program capacity to engage with fathers is a crucial part of increasing their involvement in decision-making and program delivery.

- Identifying concerns early and responding promptly– using a response-based approach to helping parents identify concerns about child development and family functioning.

Providing additional support to families facing extra challenges

- Many interventions focus on addressing one particular risk factor, and this results in a wide range of disconnected and under-funded prevention activities. Thus, interventions that are responsive to multiple and interdependent risk factors (i.e., housing, finances, family violence, etc.) should be explored and trialled.

- Ways of promoting help-seeking behaviour should be explored. There are many barriers that stop families experiencing vulnerabilities from seeking help, and it is important to explore ways to normalise help-seeking, and make it easier for families to identify where to seek appropriate help or referral.

- Use co-production and co-design approaches with parents and communities in the planning, design, delivery and evaluation of services. This will increase the likelihood that families experiencing vulnerabilities will make use of services, and that the services will address the issues of most importance to families.

- Needs-based or response-based approaches to identifying families needing additional help should be explored and trialled. These approaches identify children and families needing additional support on the basis of their expressed needs or concerns, based on family-centred tools such as the Parent Evaluation of Developmental Status (PEDS), and the Parent Engagement Resource (PER). In exploring and trialling such approaches, care should be taken to try to find ways the service system as a whole can engage families in such a way that concerns and needs can be promptly identified and responded to.

- Support a system of progressive universalism that integrates universal, secondary and tertiary services. Identify and trial different ways of linking universal and specialist services to strengthen the capacity of universal services to meet the needs of all families (i.e., the identified child or parent to continue to attend mainstream services, with additional support provided to the person *and* to the service provider). In this way, expertise is driven downwards so that capacity of the mainstream service to meet the basic needs of the child/parent/family is built.

- Provide practitioners with adequate opportunities to build supportive networks with other services. Such networks are needed if the service system is to respond promptly to the emerging needs of children, young people and families, and deliver services in a more integrated fashion. Building networks with other services should be identified as part of every practitioner's role, and time allocated accordingly.

- The Royal Commission on Family Violence has made a number of recommendations regarding the need to build a more coordinated and responsive service system for those experiencing family violence. It is likely that some of the proposed initiatives will have wider applications, and overlap with the some of the strategies for preventing and responding to child maltreatment that have been discussed in this report. These potential synergies should be explored.

Providing specific support for families at risk of child maltreatment or receiving statutory child protection services

- There are a number of evidence-based programs available for working with families involved with child protection services, and those included in the evidence-based menu should be preferred over other strategies.
- The highly sensitive and demanding nature of the work highlights the need for all those involved to be trained in relationship-building and to be provided with supportive supervision. Reducing the turnover of child protection staff should be a priority.

Providing support services to children living in out-of-home care and to their carers

- Given the evidence of how damaging frequent changes of placement or carers can be for young people in out-of-home care, ensuring continuity of care in residential settings should be a priority.
- Given the risk of young people in out-of-home care settings being abused further, ways of supporting care staff and providing independent monitoring of possible abuse should be explored.

Providing support to care leavers

- Given the lack of evidence-based programs in this area, priority should be given to trialling promising approaches.

CALD and Aboriginal populations

- There is a need for the development of evidence-based programs specifically tailored to Australian CALD and Aboriginal groups. While a number of programs exist for these populations, they lack adequate evidence of efficacy and require rigorous evaluation to show they are producing positive outcomes. These programs would benefit from expertise in developing mechanisms of evaluation to develop the evidence-base in this area.
- There is a paucity of evidence-based programs for CALD and Aboriginal populations, and priority should be given to trialling promising approaches.
- The following are specific research questions to be addressed.
  - What other programs are being developed specifically for CALD and Aboriginal populations?
  - How can these be supported to undergo rigorous evaluation, with dissemination of results to key stakeholders?
  - How are they being developed and with whom (is there community consultation with co-design and delivery occurring)?

Training and supervision

- The main training needs identified in this review included:
  - training in identifying families in need of additional support
  - training in the use of an evidence-informed decision-making framework
  - training in the use of specific evidence-based programs
  - training in relationship-based practice
  - training in trauma-informed care.

- A comprehensive review of the training needs of the workforce may be needed to establish which staff need what forms of training.

Conclusions

The principal focus of this evidence review was to identify evidence-based programs that are applicable to child welfare and child protection services and can be incorporated in the *Roadmap for Reform*. What has become apparent is that there are other important forms of evidence that need to be included, and that the development of the *Roadmap* should be based on an evidence-based *system*.

Building an evidence-based service *system* involves more than identifying evidence-based *interventions*. There are at least five types of evidence to be considered.

- Evidence regarding effective ways of identifying emerging child and family concerns and needs.

- Evidence regarding effective ways of engaging and working with families experiencing vulnerabilities and communities – *evidence-based processes.*

- Evidence regarding effective intervention strategies for improving child and family functioning and preventing child maltreatment and neglect – *evidence-based programs.*

- Evidence regarding effective ways of building parental and family strengths, and helping families learn and adopt new child rearing practices.

- Evidence regarding effective ways of integrating services so as to be able to respond in a holistic way to complex family issues.

This review has identified only the second and third types of evidence. The original brief for this paper was on the third form of evidence and on identifying evidence-based programs. The criteria for program efficacy that were applied in this review were strict, with only those programs meeting the highest standard of evidence being included on the final list. The decision to use only the strictest criteria was a pragmatic one – the project's timelines were so tight that there was insufficient time to consider programs that had promising evidence of efficacy but had not yet been tested sufficiently to be deemed proven.

The fact that only 33 programs met the highest criteria of efficacy is instructive in itself. Many more programs have been developed but have not yet been tested sufficiently to include on the list of proven programs. The fact that these programs are not on the final list does not mean they are not effective; indeed, some of these may prove to be as effective (or even more effective) than those already on the list. This gap between promising and proven practices is common, and reflects the sheer number of

interventions that have been developed, the difficulty in arranging independent trials of all of them, and the technical challenges to be overcome in testing these programs to the highest standards.

Regarding the second form of evidence – effective ways of engaging and working with families and communities experiencing vulnerabilities – it is clear that a positive practitioner-client relationship is critical if help is to be effective and positive changes are to occur. In fact, the main theme emerging from this review of evidence-based programs and processes at different service levels is the fundamental importance of relationships. This is a central plank of the evidence-informed decision-making process and also emerges at every level of service. This is particularly true of tertiary service level, whether it's working with families in child protection, working with parents who have themselves suffered complex trauma, working with children in care or with children leaving care – the relationships that those involved have with practitioners and others are the strongest factor affecting outcomes. As Winter (2015) notes, 'Throughout the different stages of their care journey, access to positive and meaningful relationships is likely to lead to better long-term outcomes for children and young people' (p. 2).

As this review has shown, the evidence indicates that more attention needs to be paid to the development of high quality relationships between professionals and children, young people and their families. Relationships should be at the heart of the care system. For those who have suffered traumatic maltreatment at some stage of their lives, sustained supportive relationships represent the most effective form of treatment. For others who have not experienced maltreatment but are facing multiple challenges, positive relationships with service providers are the medium through which evidence-based programs such as those identified in this review can be delivered effectively.

Appendix A: Overview of Menu of Evidence-Based Programs

Table 1 PROGRAMS BY OUTCOMES, CHILD AGE, MODE OF DELIVERY AND OVERALL EVIDENCE RATING

Child maltreatment outcomes

Evidence Rating Key: 1=Multiple RCTs replicating effect for relevant outcome, 2= Multiple RCTs but different outcomes assessed, 3=Single RCT, 3=Quasi-experimental design, 4=Pre-post design (no control), 5=Qualitative evaluation

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing/health	Independent living			
Triple P A suite of parenting programs. The Pathways version (for parents at risk of child maltreatment) is delivered in group or individual format after parents have completed Triple P Level 4	✓	✓	✓	✓		0-16yr	**Different options available at different levels** (private consultations, small groups, large seminars or online self-help). Pathways is delivered over two to five group or individual 60-90 minute sessions, after parents have completed Triple P Level 4.	1
Nurse Family Partnership (NFP) A home-visiting program for low income first time mothers	✓		✓	✓		0-2yr	**Home Visiting** Weekly or fortnightly 60-90 minute visits prenatal to two years	1
Parent Child Interaction Therapy (PCIT)	✓		✓	✓		2-7yr	**Family Therapy**	1

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing/health	Independent living			
Involves real-time coaching of parent-child interactions and includes observation through a one-way mirror with coaching via an earpiece							10-20 sessions of one to two hours duration	
Parents Under Pressure (PUP) A home visiting program for parents at risk of child maltreatment due to substance misuse, mental illness, financial stress or family conflict	✓ Potential		✓	✓		2-8yr	**Home Visiting** Eight to 10 sessions of 60 to 90 minutes	1
Healthy Families New York (and America) A home-visiting program for parents considered at risk of child maltreatment. Home visitors provide support, education and referrals to community services as appropriate.	✓		✓			0-5yr	**Home Visiting** Prenatally or before the infant is three months old for up to five years. Diminishing frequency.	1
Attachment and Bio-behavioural Catch Up (ABC) Parent coaching to families who have experienced child maltreatment or disruptions in care. Parent coaches provide in-the-moment feedback about caregiver-child interactions.	✓ Potential		✓	✓		6mth-2yr	**Home Visiting** 10 weekly sessions of one hour duration	2
Family Thriving Program (FTP) Delivered as an enhancement to home visiting rather than a stand-alone program. It involves cognitive appraisal methods to reframe parents' understanding of their relationship with their children	✓		✓	✓		0-1yr	**Home Visiting** Two visits per month (birth to four months), one visit per month (five to eight months), then bimonthly visits (nine to 12 months)	2
Early Start A home visiting program (NZ) delivered by Family Support Workers. The program uses a collaborative approach to problem solving and balancing family strengths with challenges as well as family and agency goals. It is delivered	✓ Potential		✓	✓		0-5yr	**Home Visiting** Up to five years, with visits ranging from weekly to monthly	3

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing/health	Independent living			
in a culturally sensitive and safe manner.								
Safe Environment for Every Kid (SEEK) Delivered by medical professionals together with mental health colleagues within primary health care settings serving children. It involves screening, and incorporates principles of motivational interviewing with the provision of information and referrals for a range of risk factors (e.g. substance abuse, mental health, intimate partner violence, food insecurity, harsh parenting)	✓		✓			0-5yr	**Motivational Interviewing, Screening and Referral**	3
SafeCare Involves home visits to parents at risk of child maltreatment or with a history of child abuse or neglect. It involves four modules: health, home safety, parent-child interaction and problem solving.	✓		✓			0-5yr	**Home Visiting** 18 to 20 weekly home visits of 60-90 minutes duration	3
Child Parent Psychotherapy (CPP) CPP aims to support and strengthen the caregiver-child relationships among those who have experienced trauma. Treatment settings can include the home (birth, adoptive, or kinship/foster), community agency, outpatient clinic, or school	✓		✓	✓		0-5yr	**Family Therapy** Child-parent dyads in weekly sessions of 60 to 90 minutes duration, for 12 months	2
Project Support Project Support is a home visiting program based on cognitive behavioural therapy, attachment and relational theories. The program aims to prevent or address behavioural problems, improve the mother-child relationship	✓		✓	✓		3-8yr	**Home Visiting** Weekly sessions of 60-90 minutes duration for up to eight months	3

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing/health	Independent living			
and reduce harsh parenting. Therapists provide emotional and instrumental support while an accompanying student mentors the child.								
Child and Family Interagency, Resource, Support and Training (ChildFIRST) ChildFIRST is a home visiting program. The program uses a relationship-based approach and aims to provide a comprehensive and integrated system of care. Program sessions are based on parent need and aim to address a range of difficulties including child and parent mental health, child development and learning difficulties, abuse and neglect.	✓ Potential		✓	✓		0-5yr	**Home Visiting** Average six to 12 months, dependent on family needs	3

Placement and family reunification outcomes

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent Living			
Triple P Triple P is a suite of parenting programs. The Pathways version (for parents at risk of child maltreatment) is delivered in group or individual format after parents have completed Triple P Level 4	✓	✓	✓	✓		0-16yr	**Different options available at different levels** (private consultations, small groups, large seminars or online self-help). Pathways is delivered over two to five group or individual 60-90 minute sessions, after parents have completed Triple P Level 4.	1
Treatment Foster Care Oregon - Adolescents, (formerly Multidimensional Treatment Foster Care – Adolescents) TFCO-A involves the placement of adolescents suffering severe emotional or behavioural problems with a trained TFCO-A family for six to nine months. Foster parents and teachers track adolescent behaviour and adolescents receive individual therapy for support and social skills coaching. Adolescents are allowed to visit birth families (when appropriate).		✓		✓		12-17yr	**Family Therapy, Individual Therapy** Six to nine month intervention. Treatment families: daily telephone support. Birth families: family therapy in preparation for the child's return home, then group aftercare sessions for up to one year	1
Treatment Foster Care Oregon for Preschoolers (TFCO-P)		✓	✓	✓		0-6yr	**Home Visiting**	1

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent Living			
(formerly Early Intervention Foster Care; EFIC) TFCO-P involves the placement of preschoolers exhibiting disruptive or antisocial behaviour with a trained TFCO-P family for six to nine months. It involves a team working intensively with the child, the foster parents, and potential permanent carers (including birth parents, adoptive relatives or non-relatives) through delivery of family therapy. A weekly therapeutic playgroup session is also implemented in some program variants							Six to nine month intervention. Foster parents receive intensive training prior to placement, and are supported with daily phone calls during placement, weekly home visits, support group meetings, and a 24 hour on-call crisis intervention	
Keep Safe (formerly Middle School Success) Keep Safe is for adolescent girls in foster care who are transitioning to middle school. In addition to group work, girls receive one-on-one sessions of ongoing training and support. Parents receive follow up group sessions.		✓		✓		12-14yr	**Group Format** Two sets of six-session groups (one for girls and one for foster parents), meeting twice per week for three weeks plus one-on-one sessions of ongoing training and support once per week for two hours during the school year. Parents receive follow up group sessions once per week for two hours during the school year.	2
Fostering Healthy Futures (FHF) FHF involves weekly skills groups and individual mentoring.		✓		✓		9-11yr	**Group Format and Individual Therapy**	2

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent Living			
Children are paired with graduate student mentors studying social work, psychology or a related field and generally mentor two children each. The group curriculum is manualised and covers cognitive behaviours strategies for emotion recognition, problem solving, anger management, cultural identity, change and loss and peer pressure							Delivered over 30 weeks. Skills groups: 90 minutes. Mentoring sessions: two hours	
Homebuilders Homebuilders is an intensive family program which aims to avoid children entering out of home care or prepare them for returning home. Therapists use crisis intervention, motivational interviewing, parent education, skill building and cognitive behavioural therapy		✓				0-18yr	**Home Visiting** Three to five face-to-face contacts of two hours duration per week, with telephone contact between sessions, for an average of four to six weeks. Two aftercare 'booster sessions' (two and a half hours each) in the six months following referral	3
Keeping Foster Parents Trained and Supported (KEEP) KEEP is a group-based parenting program delivered to foster parents in community centres or churches. Sessions are conducted by a trained facilitator and cofacilitator, covering behaviour management methods. In addition to group sessions, home visits are made when parents miss a session		✓				5-12yr	**Group Format** 16 weekly 90 minute sessions. Home visits are made when parents miss a session	3

Fostering Individualised Assistance Program (FIAP) FIAP involves wraparound teams meeting monthly with a FIAP family specialist to implement a strength-based assessment, life domain planning, clinical case management, and follow up supports and services. Teams are composed of as many relevant adults in the child's life who are willing participate, such as parents, teachers, and therapists. The specialist leads meetings with the aim of transitioning this responsibility to a parent or other adult with a consistent role in the child's life. Intensive, specialised services and supports are also provided in the child's home or in the community, depending on needs		✓		✓		**7-15yr**	**Wraparound Team** **Monthly meetings and follow up support and services**	**3**
Multi-systemic therapy for child abuse and neglect (MST-CAN) MST-CAN is delivered to families in the home. All members of the family are involved. MST-CAN staff teams include three therapists, a crisis caseworker, a part-time psychiatrist and a full-time supervisor		✓	✓	✓		6-17yr	**Home Visiting** Minimum of three sessions per week over six to nine months. Session length and frequency depend on need, and may range from 50 minutes to two hours. Multiple sessions may be conducted in one day and treatment is available 24 hours per day, seven days per week	3

Social and emotional wellbeing and health outcomes (among abused or neglected children, but without evidence of reducing maltreatment)

Note: many of the programs impacting maltreatment or maltreatment potential also demonstrate evidence of improving child mental health (e.g. Triple P, NFP, and PCIT, ABC, SafeCare, ChildFIRST, PUP, Early Start, and Project Support – see above)

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent living			
Incredible Years The Incredible Years includes programs for the child, parent and teacher. Parent programs focus on developmentally appropriate parenting skills which are known to reduce behaviour problems. The BASIC program contains a home visiting component for parents mandated to enrol due to child abuse or neglect. Child training consists of small group therapy sessions where two therapists work with six to seven children, focussing on social skills, conflict resolution, empathy-building, problem solving and cooperation			✓	✓		**0-12yr**	**Group Format** Weekly two-hour sessions for nine to 22 weeks, depending on the family. Involves a home visiting component.	**1**
Tuning Into Kids (TIK) TIK is a group-based parenting program. The program is suitable for families from a range of backgrounds, from those who are functioning well to those receiving statutory child protection services. A trauma-focused version of the program has been developed for parents/carers of children who have experienced complex trauma. For higher need/clinical participants group size is recommended not to exceed 6 families, with up to 14 for a community group.			✓	✓		**1.5-18yr**	**Group Format** Six to eight weekly sessions of two hours duration, with an additional one or two follow up booster sessions at bimonthly intervals	1

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent living			
Treatment Foster Care Oregon - Adolescents (formerly Multidimensional Treatment Foster Care - Adolescents) (as above) TFCO-A involves the placement of adolescents suffering severe emotional or behavioural problems with a trained TFCO-A family. Treatment families receive daily telephone support. Foster parents and teachers track adolescent behaviour and adolescents receive individual therapy for support and social skills coaching. Adolescents are allowed to visit birth families (when appropriate)		✓		✓		12-17yr	**Family Therapy and Individual Therapy** Six to nine month intervention. Treatment families: daily phone support. Birth families receive family therapy in preparation for the child's return home, then group aftercare sessions for up to one year	1
Kids in Transition to School Delivered to children in kinship or foster care, and to other children at risk of school difficulties, KITS involves children attending groups structured like a kindergarten class. Sessions cover self- regulation and social skills as well as literacy and numeracy. Caregivers attend 12 workshops			✓	✓		Preschool age	**Group Format** Two sessions per week for eight weeks (before school begins) and one session per week for eight weeks (after school starts), total 24 sessions. Caregivers: 12 workshops (weekly in the summer and every other week once school starts).	2
Keep Safe (formerly Middle School Success) (as above) Keep Safe is for adolescent girls in foster care who are transitioning to middle school		✓		✓		12-14yr	**Group Format** Two sets of six-session groups (one for girls and one for foster parents), meeting twice per week for three weeks, plus one-	2

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent living			
							on-one sessions of ongoing training and support once per week for two hours during the school year. Parents receive follow up group sessions (also once per week for two hours during the school year).	
Child Parent Psychotherapy (CPP) CPP aims to support and strengthen the caregiver-child relationships among those who have experienced trauma. Treatment settings can include the home (birth, adoptive, or kinship/foster), community agency, outpatient clinic, or school			✓	✓		0-5yr	**Family Therapy** Child-parent dyads in weekly sessions of 60 to 90 minutes duration, for 12 months	2
Fostering Healthy Futures (FHF) FHF involves weekly skills groups and individual mentoring, delivered over 30 weeks. Children are paired with graduate student mentors studying social work, psychology or a related field and generally mentor two children each. The group curriculum is manualised and covers cognitive behaviours strategies for emotion recognition, problem solving, anger management, cultural identity, change and loss and peer pressure		✓		✓		9-11yr	**Group Therapy and Individual Therapy** Skills groups: 90 minutes. Mentoring sessions: 2 hours	2
Multi-systemic therapy for child abuse and neglect (MST-CAN) MST-CAN is delivered to families in the home. All		✓	✓	✓		6-17yr	**Home Visiting** Minimum of three sessions per week over six to nine months.	3

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent living			
members of the family are involved. MST-CAN staff teams include three therapists, a crisis caseworker, a part-time psychiatrist and a full-time supervisor							Session length and frequency depend on need, and may range from 50 minutes to two hours. Multiple sessions may be conducted in one day and treatment is available 24 hours per day, seven days per week.	
Cognitive Behavioural Therapy for Sexually Abused Preschoolers (CBT-SAP) CBT-SAP targets child development, child behaviour, parent-child relationships and family relationships			✓	✓		3-6yr	**Family Therapy** 12 weekly sessions by professionals to individual parent-child dyads in a clinical setting. Session duration is one hour for parents and 30 to 60 minutes for children, depending on their attention span.	3
Fostering Individualised Assistance Program (FIAP) FIAP involves wraparound teams (composed of as many relevant adults in the child's life who are willing participate, such as parents, teachers, therapists) meeting monthly with a FIAP family specialist to implement a strength-based assessment, life domain planning, clinical case management, and follow up supports and services. This specialist leads meetings with the aim of transitioning this responsibility to a parent or other adult with a consistent role in the child's life. Intensive, specialised services and supports are also provided in the child's		✓		✓		7-15yr	**Wraparound Team** Monthly meeting	3

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent living			
home or in the community, depending on needs								
Big Brothers, Big Sisters BBBS aims to promote the positive development of disadvantaged youth who have risk factors such as a history of abuse or neglect. The traditional model operates within community settings and a school-based model allows weekly breaks from regular programming for the child to take part in one-to-one activities with the mentor, within the school environment				✓		6-18yr	**Mentoring** Volunteer mentors commit to spending approximately three to five hours per week with a child for at least one year	3
Together Facing the Challenge TFC is a group-based parenting program designed for treatment foster parents, caregivers and agency staff managing children with emotional and behavioural problems				✓		3-17yr	**Group Format** Foster parents attend six weekly sessions of two hours duration, with follow-up booster offered at six and 12 months post-training	3
Life story intervention Life story intervention is a narrative- and relationship-based intervention aiming to provide information and correct misinformation about substance abuse, encourage a sense of mastery over traumatic events, and improve the mental health of foster children. It is delivered by community-based professionals experienced in working with children (e.g. teachers, counsellors, child welfare workers)				√✓		7-17yr	**Home Visiting** The intervention occurs over a seven month period and involves weekly individual one hour sessions delivered in and around the child's home	3

Empowering Families, Empowering Communities (EPEC) EPEC involves training and supporting local parents to run peer-to-peer parenting groups in schools and children's centres. Parent leaders take part in facilitator training to deliver the 'Being a Parent' course and then pairs of parent facilitators deliver the course to groups of other parents in their community			✓	✓		**0-11yr**	**Group Format** **Facilitator training runs one day per week for 10 weeks (60 hours). The peer-led Being a Parent course runs for two hours per week over eight weeks (total 16 hours)**	**3**

Transition to independent living outcomes

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent Living			
Take Charge (care leavers) Take Charge is for adolescents with special education needs who are in foster care, leaving care or transitioning from care. It focuses on self-determination and provides academic support, as well as transition education and planning for those leaving care. Weekly coaching sessions are delivered to young people in the school setting by trained and supervised coaches. Mentoring is also provided by adults with disabilities who have transitioned from foster care to independent living. The program also provides support for families				✓	✓	Adolescents	**School Based** Weekly individual coaching sessions for 12 months	**1**
Massachusetts Adolescent Outreach Program for Youths in Intensive Foster Care MA Outreach is a relationship-based program involving one-on-one work with young people in foster care to prepare them for adulthood. The program's services are individualised for each participant. Outreach workers directly assist participants with a variety of tasks and may refer participants to other organisations		✓			✓	Adolescents	**Outreach** Meetings typically occur weekly, although frequency is flexible to suit each participant's needs. On average, participants are involved with the program for two years, comprising 16 to 18 months of services followed by approximately six months of less frequent contact (i.e. monthly)	3

Programs designed for Aboriginal[7] and Culturally and Linguistically Diverse Australian populations

Program	Outcomes					Child Age	Delivery and Duration	Evidence Rating
	Maltreatment	Placement	Family functioning	Child social or emotional wellbeing or health	Independent living			
Bending Like a River Bending Like A River aims to strengthen the abilities of culturally and linguistically diverse parents to parent confidently and capably in Australia. Topics include intergenerational conflict, benefits of bicultural parenting identity, knowledge of the Australian school system, discipline strategies, knowledge of Australian child abuse laws and support services. Sessions are solutions-focused and use a strengths based approach			✓			6-12y *flexible*	**Group Format** Single session or six week program, however the six week group format is recommended to allow participants to build supportive relationships and develop trust over time.	5
Take Two (including Yarning Up on Trauma) Take Two is a developmental therapeutic program for children and young people in the Victorian Child Protection system. The program works intensively with the distressed child or young person, and their carers, families and teachers, to help them understand their pain and learn to trust again. 'Yarning Up on Trauma' is a Take Two education package which provides an approach to understanding trauma and attachment for Aboriginal children, Aboriginal communities and those working with the Aboriginal community				✓		0-18y	**Group Format and Individual Therapy** **D**elivered flexibly with frequency and duration of sessions depending on the content of individual family plans	4&5

[7] Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

Appendix B: Menu of Evidence-Based Programs

Maltreatment outcomes

Best Practice

Program name	TRIPLE P (Positive Parenting Program)
Originator/Organisation	Professor Matt Saunders, Parenting and Family Support Centre, University of Queensland Triple P International
Aims and conceptual base	Triple P helps parents learn simple and practical strategies to manage their children's behaviour, prevent problem behaviour and build strong, healthy relationships. The California Evidence-Based Clearinghouse describes the overall goal of Triple P as preventing the development or worsening of severe behavioural, emotional and developmental problems in children and adolescents by enhancing the knowledge, skills and confidence of parents.
Target population / eligibility	Triple P is available as a 'system' of five levels of intervention for parents of children up to 12 years, with Teen Triple P for parents of 12 to 16 year olds. Level 5 includes Enhanced Triple P for parents dealing with partner conflict, stress or mental health issues and Pathways Triple P for parents at risk of child maltreatment. Specialist Triple P programs for families with particular needs include Stepping Stones (for parents of children with disabilities), Family Transitions (for parents going through separation or divorce, Lifestyle (for parents of children who are overweight) and Indigenous (for Indigenous parents).
Intervention level(s)	Families who function well Families who have some difficulties Families at risk of child maltreatment Families receiving statutory child protection services Children living in out-of-home care
Delivery mode	Flexible delivery with multiple options (group sessions, online sessions, self-directed workbook, individual sessions)
Core program components	Different content at each level. At Level Five, Enhanced Triple P includes three modules that target partner relationships and communication, personal coping strategies for high stress situations and other positive parenting practices. Pathways Triple P covers anger

	management and other behavioural strategies to improve parenting abilities.
Associated outcomes	• Fewer behavioural problems • Fewer emotional problems • Higher self-esteem • Fewer psychosocial difficulties overall • Increased parental self-efficacy • Reduced coercive parenting • Improved parent-child relationship • Increased use of positive parenting methods • Reduced marital conflict • Lower level of parental depression • Reduced parental stress • Lower level of parental anger • Fewer cases of child maltreatment • Lower rates of hospitalization and fewer emergency room visits resulting from maltreatment • Fewer cases in which children have to be placed in the care of a guardian or foster parent or a residential home as a result of maltreatment • Reduced occupational stress • Higher work satisfaction • High levels of client satisfaction.
Evidence of effectiveness	Outcomes listed above have been extracted from the United Nations Office Drugs and Crime's (UNODC) Compilation of Evidence-Based Family Skills Programs. The Compilation summarises the available evidence for Triple P as including four meta-analyses of Triple P studies, 10 independent randomised control trials, 47 randomised control trials, 28 quasi-experimental studies and 11 studies based on pre- and post-intervention evaluation. The Triple P evidence-base hosted by the University of Queensland contains a total of 580 articles which have made a contribution to the evaluation and continuing evolution of the Triple P system.
Effect size or measures of impact	A large population study of the Triple P system in the US found the intervention group had lower substantiated child maltreatment, child out-of-home placements and child maltreatment injuries compared to controls (Prinz, Sanders, Shapiro, Whitaker & Lutzker, 2009). These were reported as large effects.
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes, over multiple sites/studies. The Triple P system is rated a near top-tier program by the Coalition for Evidence-Based policy, a 'promising' program by Blueprints,

	'promising' according to the Promising Practices Network and has received a scientific rating of two from the California Evidence-Based Clearinghouse where it is listed as supported by research evidence. Level 4 of Triple P received a scientific rating of one from the California Evidence-Based Clearinghouse where it is listed as well-supported by research evidence. The UNODC Compilation cautions that the impact of Triple P varies considerably depending on the level of the intervention (i.e. population or individual), particular level of the program delivered, relevant outcome measures and the research methodology used.
Training and accreditation requirements	Different accreditation requirements apply to different levels of the system and different specialised programs. See: http://www.triplep.net/files/6414/5525/1195/Triple_P_System_Table.pdf
Acceptability	As Triple P is already implemented nationally across Australia, this program is likely to be acceptable to professionals and clients new to the intervention.
Use in Australia	Extensive.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	Developed in Queensland, already implemented in Victoria.
Anticipated challenges to implementation in Victorian context	None.
Indicative scale of implementation costs	Blueprints estimates Triple P System first year cost at as $2,367,393 (US) in a community serving 100,000 families or $23.67 (US) per family (population level).
Name of organisation holding Australian licence (if applicable)	Triple P International
References	Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P System population trial. *Prevention Science*, 10, 1-12. United Nations Office on Drugs and Crime (no date). Compilation of Evidence-Based Family Skills Training Programmes. Available at: https://www.unodc.org/docs/youthnet/Compilation/10-

	50018_Ebook.pdf Websites: http://www.triplep.net/ http://www.blueprintsprograms.com/factsheet/triple-p-system http://toptierevidence.org/ http://www.cebc4cw.org/program/triple-p-positive-parenting-program-system/detailed http://www.promisingpractices.net/program.asp?programid=272

Program name	**NURSE FAMILY PARTNERSHIP (NFP)**
Originator/Organisation	Professor David Olds, University of Colorado Denver
Aims and conceptual base	NFP is a nurse-led home visiting program aiming to improve outcomes for children and families through the provision of preventative support throughout pregnancy, infancy and toddlerhood.
Target population / eligibility	Low income, first time mothers.
Intervention level(s)	Families experiencing some difficulties Families at risk of child maltreatment Families receiving statutory child protection services.
Delivery mode	Weekly or fortnightly home visits from pre-natal to 24 months postpartum. Visits are generally 60-90 minutes duration.
Core program components	First-time, low-income mothers are enrolled in the program early in their pregnancy. Trained public health nurses deliver home visits from pregnancy (no later than week 28 of pregnancy) to the time children are two and a half years old. Nurse home visitors emphasise self-efficacy, human ecology and attachment theories.
Associated outcomes	• Reduced abuse/neglect[1] • Hospitalization for injuries and illness[1] • Child language and mental development[1] • Improved prenatal health[2] • Fewer childhood injuries[2] • Fewer subsequent pregnancies[2] • Increased intervals between births[2] • Increased maternal employment[2] • Improved school readiness[2] • Child behaviour problems at age 6 years[3] • Child internalizing problems and substance use at 12 years[3] • Child arrests and convictions at 19 years[3]
Evidence of effectiveness	[1]These outcomes have been demonstrated in three RCTs (see http://www.blueprintsprograms.com) [2]These outcomes have been demonstrated in at least two RCTs, (see http://www.nursefamilypartnership.org/proven-results) [3]These outcomes have been demonstrated in at least one RCT (see http://www.blueprintsprograms.com)
Effect size or measures of impact	48% reduction in state-verified rates of child abuse and neglect (Olds et al., 1997).

	56% relative reduction in emergency department visits for injuries and ingestions in the child's second year of life (Olds et al 1986). 4.5 times lower mortality rate among intervention children in the first 9 years of life, accounted for by deaths due to prematurity, SIDS, and injury (Olds et al., 2007)
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes, over multiple sites/studies, with maintenance of some effects demonstrated up to 15 years post intervention. It is rated a top-tier program by the Coalition for Evidence-Based policy, a 'model' program by Blueprints, and 'Proven' according to the Promising Practices Network.
Training and accreditation requirements	Nurse home visitors must complete three units of training including 40 hours of orientation self-study, 25 hours of face to face workshops over four days and 10 hours of distance education and professional development. Supervisors must complete an additional 10 hours of self-study, an additional four days of face to face training, ongoing consultation with a Nurse Family Partnership Nurse Consultant and annual face to face supervisor education and refresher training (20 hours over three days).
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by multiple RCTs with demonstrated effects on relevant child and parent outcomes. The program is also likely to be acceptable to clients. This first evaluation of the NFPP in Australia provides evidence from semi-structured interviews and observation at implementation sites indicating that the program is suitable and acceptable to Aboriginal and Torres Strait Islander families within the Australian context (Department of Health and Aging, 2012).
Use in Australia	Delivered in Australia as The Australian Nurse-Family Partnership Program (ANFPP) targeting Aboriginal and Torres Strait Islander families in the Northern Territory, Queensland and the Australian Capital Territory. http://www.anfpp.com.au
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	Program has been adapted for use with Aboriginal and Torres Strait islander families in the Australian health care system.
Anticipated challenges to implementation in	None

Victorian context	
Indicative scale of implementation costs	Blueprints estimation of costs to set up and operate for one year (team of eight nurses and one supervisor, serving approximately 200 families) is as follows: Initial training, salaries for one month, equipped office $77,000 (US) Staff Salaries for one year $711,000 (US) Travel $21,000 (US) Technical assistance and fidelity monitoring $8,800 (US) Overhead and office (25% of staff) $197,000 (US) Total estimated year one cost $1,014,800 (US) With eight nurses and a caseload of 25 families per nurse, 200 families would be served at a cost of $5,074 (US) per family for one year of services.
Name of organisation holding Australian licence (if applicable)	N/A
References	Department of Health and Ageing (2012) Stage 1 Evaluation of the Australian Nursing Family Partnership Program. Final Report. Olds D, Eckenrode J, Henderson C, Kitzman H, Powers, J, Cole R, Sidora K, Morris P, Pettitt L, Luckey D. (1997) Long-term effects of home visitation on maternal life course and child abuse and neglect: a 15-year follow-up of a randomized trial. JAMA: 278(8):637-643. Olds DL, Henderson CR Jr., Chamberlin R, Tatelbaum R. (1986). Preventing child abuse and neglect: a randomized trial of nurse home visitation. Pediatrics, 78(1):65-78. Olds DL, Kitzman H, Hanks C, Cole R, Anson E, Sidora-Arcoleo K, Luckey DW, Henderson CR Jr., Holmberg J, Tutt RA, Stevenson AJ, Bondy J. (2007). Effects of nurse home visiting on maternal and child functioning: age-9 follow-up of a randomized trial. Pediatrics, 120(4):e832-845. Websites: http://www.nursefamilypartnership.org/ http://www.blueprintsprograms.com

Program name	PARENT CHILD INTERACTION THERAPY (PCIT)
Originator/Organisation	Dr Sheila Eyberg PCIT International
Aims and conceptual base	PCIT aims to improve the quality of parent-child relationships and change parent-child interaction patterns. It does this by teaching parents the skills to establish a nurturing and secure relationship with their child, encouraging the child's prosocial behaviour and discouraging negative behaviour.
Target population / eligibility	Caregivers of young children (two to seven years) with emotional, behavioural and parent-child relationship issues.
Intervention level(s)	Families experiencing some difficulties Children at risk of maltreatment Families receiving statutory child protection services Children living in out of home care
Delivery mode	10 to 20 sessions of 1 to 2 hours duration, delivered weekly (average 14 sessions)
Core program components	PCIT involves two phases: (1) Child-Directed Interaction (CDI), and (2) Parent Directed Interaction (PDI). CDI involves use of 'PRIDE' skills (Praise, Reflection, Imitation, Description and Enthusiasm) and avoiding questions, commands and criticism. Parents follow their child's lead and are coached with real-time feedback from a therapist. Parents are assessed during CDI and begin PDI once the therapist is satisfied they are ready. PDI involves parents learning skills to lead their child's behaviour when the child must obey an instruction (issuing commands). Parents are observed through a one-way mirror and coached using an ear piece device.
Associated outcomes	• improved parenting/reductions in negative parent behaviour[1] • reduced behaviour problems/improved behaviour[2] • reduced parenting stress[3] • fewer re-reports of child abuse[3] • improved parent locus of control[4] • reduced negative emotions[4] • improved parent-child interactions[4] • improved maternal sensitivity[4] • reduced child abuse potential[4]
Evidence of effectiveness	[1]This outcome has been demonstrated in four RCTs (see http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed) [2]This outcome has been demonstrated in five RCTs (see and Thomas & Zimmer-Gembeck (2011))

	[3] This outcome has been demonstrated in three RCTs (see http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed and Thomas & Zimmer-Gembeck (2011)) [4] These outcomes have been demonstrated in one RCT (see http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed Thomas & Zimmer-Gembeck (2011))
Effect size or measures of impact	Child welfare recidivism was reduced from 49% to 19% over a two year follow up period, compared with a services as usual (Chaffin et al, 2004) This finding of reduced re-reports was replicated using multiple imputation and survival analysis in a field study (Chaffin et al, 2011). Thomas & Zimmer-Gembeck (2011) reported a clinically significant decrease in child abuse potential for 17.5% of PCIT treatment group participants from pre-assessment to treatment protocol completion. Of families completing PCIT treatment protocol, 17% were notified to state welfare organisations after treatment completion compared to 43% of the families who did not complete the treatment.
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes, over multiple sites/studies, with maintenance of reduced re-reports of child abuse demonstrated up to two years post intervention. It has received a scientific rating of one (out of five) from the California Evidence-Based Clearinghouse, where it is listed as 'well-supported' by research evidence and is listed as 'promising' by Blueprints. Chaffin et al (2011) note that results were obtained at a single agency with a small number of part time clinicians and so generalisation to other settings should be made cautiously. External service factors (i.e. other services families were receiving) were also uncontrolled in the field setting. As control participants in Thomas & Zimmer-Gembeck's (2011) study received PCIT after the 12-week intervention wait period, comparisons on child welfare outcomes could only be drawn between those who completed PCIT and those who received PCIT but did not complete the full intervention.
Training and accreditation requirements	To deliver PCIT, practitioners must complete a five-day training course and 40 hours of practical experience, and an additional follow up two-day training course. Both courses are accompanied by six months of clinical supervision. In Australia, training is delivered through Karitane.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by several RCTs. It is already listed on the Victorian Department of Education and Training's website as a recommended strategy to reduce re-notifications to child

	protection. The program is also likely to be acceptable to clients.
Use in Australia	Yes
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	Already available in Australia.
Anticipated challenges to implementation in Victorian context	None.
Indicative scale of implementation costs	Blueprints estimation of costs includes: $3,000-4,000 (US) for intitial training (per participant) $200 (US) per organisation for certification The model often requires modification of space (addition of a one-way mirror to adjacent rooms, sound equipment and toys) at an estimated cost of $1,000 to $1,500 (US) An Eyberg Child Behavior Inventory is administered weekly to each parent at a cost of $40 for 25 forms.
Name of organisation holding Australian licence (if applicable)	Karitane
References	Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., … Bonner, B. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing further abuse reports. *Journal of Consulting and Clinical Psychology*, 72(3), 500-510. Chaffin, M., Funderburk, B., Bard, D., Valle, L.A., & Gurwitch, R. (2011). A motivation-PCIT package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology*, 79(1), 84-95. Thomas, R. & Zimmer-Gembeck, M.J. (2011). Accumulating Evidence for Parent-Child Interaction Therapy in the Prevention of Child Maltreatment. *Child Development,* 82(1), 177-192. Websites: http://www.blueprintsprograms.com/factsheet/parent-child-interaction-therapy http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed

Program name	PARENTS UNDER PRESSURE (PUP)
Originator/Organisation	Professor Sharon Dawe and Dr Paul Harnett
Aims and conceptual base	PUP aims to strengthen parent's confidence in their parenting role. Through the use of CBT, attachment/relational theory and mindfulness techniques, PUP helps parents to develop skills to help them cope with negative emotional states. The program focuses on prevention and aims to equip parents with positive parenting skills, extend social networks and strengthen relationships between partners.
Target population / eligibility	Families of children aged two to eight years who are at risk of neglect or abuse due to parental substance abuse problems, mental illness, financial stress or family conflict.
Intervention level(s)	Families at risk of child maltreatment
Delivery mode	Delivered by professionals to individual parents in the home. Eight to 10 weekly sessions of 60 to 90 minutes duration.
Core program components	PUP comprises 10 modules beginning with an individualised assessment and case plan developed closely with parents. Modules focus on positive parenting skills (praise, rewarding good behaviour, child-centred play skills), and encourage non-punitive child management techniques such as time out. The program also covers communication skills to strengthen relationships and social networks, and equips parents with coping skills for lapse and relapse (to use of alcohol and drugs). Many practical life skills are also covered including diet and nutrition, budgeting, health care and exercise. Flexibility within the program allows for further case management outside of treatment sessions if necessary to help with housing, legal advice, school intervention etc.
Associated outcomes	• Improved child behaviour problems and pro-social behaviour [1, 2] • Improved child safety and physical wellbeing [1] • Improved parental mental health [2] • Reduced child abuse potential [1, 2] • Reduced parenting stress[1] • Lower parental methadone use [1, 2] • Less rigid or harsh parenting beliefs and attitudes[1]

Evidence of effectiveness	[1]These outcomes have been demonstrated in a six month post RCT follow up (see Dawe & Harnett, 2007; Macvean et al 2013) [2]These outcomes have been demonstrated in at least two RCTs (see Stewart-Brown & McMillan, 2010)
Effect size or measures of impact	36% of the PUP group, 17% of the brief intervention group and 0% of the control group exhibited a change in status from high risk to low risk of child abuse and neglect (Dawe & Harnett, 2007). Conversely, 42% of the control group exhibited a change from low risk to high risk of child abuse and neglect compared to 0% of the PUP group (Dawe & Harnett, 2007) PUP group participants displayed significant improvements across multiple domains of family functioning including a large effect for increased child prosocial scores (Dawe & Harnett, 2007)
Analysis of evidence of effectiveness	This program is supported by at least two RCTs examining psychological, emotional and behavioural outcomes of children aged two to eight years who are at risk of abuse or neglect, with maintenance of effects demonstrated up to six months post intervention. Limitations of the studies include a short time frame of follow up (six months post treatment) and reliance on self-report measures (though well validated). Participant dropout rates were low. Two of the 20 PUP program participants, three of the 23 brief intervention participants and six of the 19 standard care group were unable to be assessed at the six month follow-up.
Training and accreditation requirements	Clinicians are required to undergo training and supervision in the PUP model. The program involves 30 hours of training and clinical supervision, plus further clinical supervision on a minimum of three family cases to receive accreditation. No formal qualifications are required prior to training. Once accredited as a PUP Therapist clinicians can gain accreditation as a PUP Clinical Supervisor. Whilst in training, Clinical Supervisors receive a minimum of five hours clinical supervision from their Trainer and will need to demonstrate competency via at least one video-taped supervision session. Further information regarding training can be found at: http://www.pupprogram.net.au/media/9319/training%20overview.pdf

Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by multiple RCTs with six month follow up and demonstrated effects on relevant child outcomes The program is also likely to be acceptable to clients as it is an Australian program and is being developed to suit Indigenous Australian populations.
Use in Australia	Yes
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	Program is used in Australia. Modules are adaptable and can be tailored to individual needs of each family.
Anticipated challenges to implementation in Victorian context	None
Indicative scale of implementation costs	Training and clinical supervision is approximately $3,000 per clinician (excluding travel). Supervision is conducted in groups of 2 via both telephone and face-to-face sessions. Training as a PUP Supervisor will cost approximately $2000. Costs for training a practitioner will be reduced to $1500 if the agency has a trained supervisor. A larger scale training price is available on application.
Name of organisation holding Australian licence (if applicable)	http://www.pupprogram.net.au/
References	Australian Centre for Posttraumatic Mental Health and Parenting Research Centre. (2014). *Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect: Evidence, practice and implications*. Dawe, S., & Harnett, P. (2007). Reducing potential for child abuse among methadone maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment*. 32, 381–390 Macvean, M., Mildon, R., Shlonsky, A., Devine, B., Falkiner, J.,

	Trajanovska, M., D'Esposito, F. (2013). Evidence review: An analysis of the evidence for parenting interventions for parents of vulnerable children aged up to six years (commissioned by the Families Commission of New Zealand), Parenting Research Centre, Melbourne. Stewart-Brown, S., & McMillan, A, S. (2010). Home and community based parenting support programmes and interventions. *Warwick Medical School, University of Warwick.* http://www.pupprogram.net.au/

Program name	HEALTHY FAMILIES NEW YORK (HFNY)
Originator/Organisation	Healthy Families New York New York State Office of Children and Family Services
Aims and conceptual base	HFNY aims to improve the health and well-being of children at risk for abuse and neglect by providing an intensive home visiting service. It is based on the US-wide 'Healthy Families America' home visiting program. Goals include: 1. Promoting positive parenting skills and parent-child interaction; 2. Preventing child abuse and neglect; 3. Ensuring optimal prenatal care and child health and development; and 4. Increasing parents' self-sufficiency.
Target population / eligibility	Expectant parents and parents of infants (less than three months old) who are considered at high risk for child abuse and neglect.
Intervention level(s)	Families who have some difficulties Families at risk of child maltreatment Families receiving statutory child protection services
Delivery mode	Home visits are scheduled one or more times per week during pregnancy (Level 1) Families usually remain on Level 1 until the child is at least six months old. As families progress through the service levels, home visits occur on a diminishing schedule, from biweekly (Level 2), to monthly (Level 3), and then quarterly (Level 4). Support is available for up to 5 years, and finishes when the child starts school or Head Start.
Core program components	Home visitors provide families with support, education, and referrals to community services aimed at addressing the program goals.
Associated outcomes	• lower likelihood of low birth weight babies[1] • fewer acts of very severe physical abuse[2] • fewer acts of minor physical aggression[2] • fewer acts of harsh parenting[3] • fewer acts of psychological aggression[1] • higher likelihood of parents using positive parenting skills[2] • higher likelihood participating in gifted programs[1] • improved receptive vocabulary[1] • lower rates of initiation of welfare cases[1] • smaller number of total confirmed child protection service reports[1]
Evidence of effectiveness	[1]These outcomes have been demonstrated in one RCT (see: http://www.promisingpractices.net/program.asp?programid=147) [2] These outcomes have been demonstrated in two RCTs (see http://www.promisingpractices.net/program.asp?programid=147) [3] This outcome has been demonstrated in three RCTs (see

	http://www.promisingpractices.net/program.asp?programid=147)
Effect size or measures of impact	At two years post-intervention, DuMont et al (2008) found intervention families self-reported committing fewer acts of serious physical abuse (0.01) and physical aggression (2.4), compared to the control group (0.08 and 3.46 respectively). These effects were maintained at seven year follow up (DuMont et al 2011), where intervention families reported less serious abuse (0.03) and children reported less physical aggression (70.8%) than controls (0.15 and 77.2% respectively). Looking specifically at a subgroup of the sample including women who had at least one substantiated child protective services report, at seven year follow up intervention mothers had lower rates of preventative, protective and placement services initiation (38.02%) compared with controls (60.02%) (DuMont et al, 2011). Intervention mothers also had smaller numbers of total confirmed reports (0.8) compared to controls (1.6) (DuMont et al, 2011).
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes with maintenance of some effects demonstrated up to seven years post intervention. It is rated as 'Proven' according to the Promising Practices Network. The broader Healthy Families America program (of which HFNY is an adaptation) has received a scientific rating of one from the California Evidence-Based Clearinghouse and is listed as well-supported by research evidence. It is also listed as an evidence-based early childhood home visiting delivery model by the US Department of Health and Human Services' Home Visiting Evidence of Effectiveness website. DuMont et al (2008) note that despite high rates of study retention, they observed significant program attrition. Available as a five year program, by two years into the study only one third of participants remained in the program. As a result, most participants received less treatment than intended by the model which likely diluted estimates of the program's effects. DuMont et al (2008) noted the importance of identifying barriers to retention in the program and investigation of strategies to sustain engagement. DuMont et al (2011) suggested that a large drop in retention from three years to four years may be due to children's enrolment in other programs, including kindergarten.
Training and accreditation requirements	A one-week core training program is provided by approved Healthy Families America trainers. Training is provided on parent-child interactions, child development, strength-based service delivery, and other topics including domestic violence, substance abuse issues, abuse and neglect, and well-baby care. HFNY supervisors receive four additional days of training.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by

	multiple RCTs with demonstrated effects on relevant child outcomes. It has been rolled out extensively in the United States as Healthy Families America. The program is also likely to be acceptable to clients willing to receive home visits over an extended period of time.
Use in Australia	No.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	Healthy Families America has been implemented across 39 states in the US, American Samoa, the US Virgin Islands and Canada, among other sites. Given this diversity, it is likely adaptable for implementation in Australia.
Anticipated challenges to implementation in Victorian context	None.
Indicative scale of implementation costs	DuMont et al (2011) provide a breakdown of costs across three sites over seven years. Overall, average total program cost per family, per year was $2,796.63 (US) from 2000-2007.
Name of organisation holding Australian licence (if applicable)	N/A
References	DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M. and Dorabawila, V. (2008). Healthy Families New York (HFNY) Randomized Trial: Effects on Early Child Abuse and Neglect. *Child Abuse and Neglect* 32, 295-315. DuMont, K., Kirkland, K., Mitchell-Herzfeld, S., Ehrhard-Dietzel, S., Rodriguez, M., Lee, E., Layne, C., and Greene, R. (2011). Final Report: A Randomized Trial of Healthy Families New York (HFNY): Does Home Visiting Prevent Child Maltreatment? http://www.ncjrs.gov/pdffiles1/nij/grants/232945.pdf Websites: http://www.healthyfamiliesnewyork.org/ http://www.promisingpractices.net/program.asp?programid=147#findings http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/detailed http://homvee.acf.hhs.gov/Model/1/Healthy-Families-America--HFA--In-Brief/10

Promising

Program name	**ATTACHMENT AND BIO-BEHAVIOURAL CATCHUP (ABC)**
Originator/Organisation	Dr Mary Dozier, University of Delaware
Aims and conceptual base	ABC was developed to help caregivers provide nurturing care to young children who have experienced early maltreatment or disruptions in care. It targets child development, child behaviour and the parent-child relationship. The California Evidence-Based Clearinghouse indicates the aims of ABC are to: • Increase caregiver nurturance, sensitivity, and delight • Decrease caregiver frightening behaviours • Increase child attachment security and decrease disorganised attachment • Increase child behavioural and biological regulation
Target population / eligibility	Caregivers of children from six months to two years who have experienced maltreatment or disruptions in care. Family members and other children are welcome to attend sessions.
Intervention level(s)	Families receiving statutory child protection services Children living in out-of-home-care
Delivery mode	10 weekly, one hour sessions in the home.
Core program components	Caregivers are trained by a parent coach to learn to re-interpret children's behaviour, engage with their own attachment issues and provide a responsive, predictable environment to enhance their child's behaviour and regulatory abilities. Sessions take place in families' homes. The primary role of the parent coach in sessions is to provide 'In the Moment' feedback about the caregivers' interactions with the child. Other activities include video-feedback and homework.
Associated outcomes	• More secure attachment[1] • More normative cortisol production[2] • Improved emotion expression[1] • Improved maternal sensitivity[1] • Improved self-regulation[1] • Reduced child abuse potential[1] • Reduced parenting stress[1] • Reduced internalising and externalising child behaviours[1]
Evidence of effectiveness	[1]These outcomes have been demonstrated in one RCT (see http://www.infantcaregiverproject.com/#!research-supporting-abc/c684) [2] This outcome has been demonstrated in three RCTs (see http://www.infantcaregiverproject.com/#!research-supporting-

	abc/c684)
Effect size or measures of impact	71.6% reduction in caregivers' self-reported Child Abuse Potential Inventory change scores, compared to 0.01% reduction in wait-list controls (Sprang, 2009)
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes, over multiple studies including families with children of at-risk birth parents and children in foster care. It has been given a scientific rating of one (out of five) by the California Evidence-Based Clearinghouse, where it is listed as 'well-supported' by research evidence. While some outcomes have been subject to follow up studies to observe how effects have been sustained over time, there was no follow up in relation to reduction in child abuse potential over time.
Training and accreditation requirements	Three days of Parent Coach training at the University of Delaware, followed by one year of videoconference supervision (90 minutes weekly, including group supervision and individual supervision in 'In the Moment' commenting) to become a Certified Parent Coach
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by multiple RCTs with demonstrated effects on relevant child outcomes. The program is also likely to be acceptable to clients.
Use in Australia	The US Department of Health & Human Services' Home Visiting Evidence of Effectiveness entry on ABC suggests that the program has been implemented in Australia, however details were not located.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	While implementation is structured, it is based on caregiver-child interactions and can therefore be adapted to the needs of different families.
Anticipated challenges to implementation in Victorian context	None
Indicative scale of implementation costs	The National Child Traumatic Stress Network estimates the cost of training and one year of weekly supervision is $5,000 per practitioner for one year.
Name of organisation	N/A

holding Australian licence (if applicable)	
References	Sprang, G. (2009). The Efficacy of a Relational Treatment for Maltreated Children and their Families. *Child and Adolescent Mental Health,* 14(2), 81-88. Websites: http://www.infantcaregiverproject.com/#!about_us/cjg9 http://www.cebc4cw.org/program/attachment-and-biobehavioral-catch-up/detailed http://www.nctsn.org/sites/default/files/assets/pdfs/abc_general.pdf

Program name	FAMILY THRIVING PROGRAM (FTP)
Originator/Organisation	Daphne B. Bugental University of California, Santa Barbara
Aims and conceptual base	FTP uses cognitive appraisal methods to reframe parents' understandings of the relationship between themselves and their children, aiming to prevent child abuse and neglect.
Target population / eligibility	Parents at risk of abusing or neglecting infants.
Intervention level(s)	Families at risk of child maltreatment Families receiving statutory child protection services Children living in out-of-home care
Delivery mode	Delivered as an enhancement to home visiting (not stand alone) as follows: • Birth to four months: two visits per month • Five to eight months: one visit per month • Nine to 12 months: Bimonthly visits Up to three additional visits available in special circumstances, when there is some special crisis or need.
Core program components	Parents are coached to re-think the causes of caregiving challenges and to become information seekers and problem solvers. Alternative ways of interpreting challenges are suggested to parents and information is provided in relation to developmental issues, available community supports and recommendations about how to solve existing problems.
Associated outcomes	• fewer instances of harsh parenting • improved child health • reduction in corporal punishment • reduction in injury • improved home safety maintenance • elevated sense of self-efficacy in the parent-child relationship • reduced cortisol levels at one and three year post intervention assessments • improved child verbal short-term memory • lower avoidance tactics
Evidence of effectiveness	The above outcomes have been demonstrated across three RCTs (each outcome demonstrated in one of the three RCTs) see: http://www.promisingpractices.net/program.asp?programid=271

Effect size or measures of impact	Bugental and Schwartz (2009) reported a small to medium effect for reduction in corporal punishment (21% of parents reported some corporal punishment in the intervention group compared with 35% in the control group), with small to medium effects also reported in relation to reduction in injury and improved home safety maintenance in the intervention group. Bugental, Schwartz and Lynch (2010) reported a medium sized effect for reduction in children's cortisol levels in the intervention group, with a large effect for intervention parents' lower use of avoidance tactics compared with controls.
Analysis of evidence of effectiveness	As an enhancement to home visiting, this program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes. It is rated as 'Proven' according to the Promising Practices Network. Bugental, Schwartz and Lynch (2010) note that most of their participant families were Latino and state that effects may differ in other populations. They also indicated that families included were highly susceptible to risk and that it is important to determine effects of the program in populations facing lower levels of risk. Uncontrolled waking time (relevant to cortisol production) and reliance on maternal self-report measures were listed as further limitations. Bugental and Schwartz (2009) also reported a biased sample.
Training and accreditation requirements	Training materials publically available from the developer's website: http://www.psych.ucsb.edu/~bugental/
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by RCT evidence with demonstrated effects on relevant child outcomes and could be implemented as part of a home visiting program. Although the program has been validated with Latino families in the US, the program may also be acceptable to Australian clients.
Use in Australia	No.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	As the program focuses on re-framing parents' understanding of their relationship with their children, content is individualised and

	thus likely to be adaptable to the local context.
Anticipated challenges to implementation in Victorian context	Unclear if more detailed training materials are available to guide implementation. It is not a standalone program and would need to be incorporated as an enhancement to home visiting.
Indicative scale of implementation costs	Unavailable.
Name of organisation holding Australian licence (if applicable)	N/A.
References	Bugental, D. B., Ellerson, P.C. et al. (2002). A Cognitive Approach to Child Abuse Prevention, *Journal of Family Psychology*, 16(3) 243-258 Bugental, D. B., & Schwartz, A. (2009). A Cognitive Approach to Child Mistreatment Prevention Among Medically At-Risk Infants, *Developmental Psychology*, 45(1) 284-288. Bugental, D. B., Schwartz, A., Lynch, C. (2010). Effects of an Early Family Intervention on Children's Memory: The Mediating Effects of Cortisol Levels, *Mind, Brain, and Education*, 4(4) 159-170.

Program name	EARLY START (ES)
Originator/Organisation	Early Start Project Ltd 136 Holly Rd, Christchurch 8014 New Zealand
Aims and conceptual base	ES aims to support families and enable them to provide their children with a positive and enjoyable childhood. Using a planned, focused and systematic approach to intervention ES aims to enable families to: • Learn and apply nurturing parenting practices • Discover personal strengths and abilities • Develop new skills and practices • Challenge negative and destructive life habits • Maximise positive outcomes for the child, parents and family.
Target population / eligibility	Families with new born babies who are at risk of maltreatment due to violence, intimate partner violence, substance abuse etc.
Intervention level(s)	families at risk of child maltreatment
Delivery mode	Participation is voluntary and free ES is a home based intervention program delivered by Family Support Workers. Families participate for up to five years with visits ranging from weekly to monthly. Family Support Workers use a collaborative approach to problem solving to find a balance between: • Family strengths and challenges • Family generated goals and agency generated goals ES is delivered in a culturally sensitive and safe manner by respecting individual family values, ethnicities and customs, needs, dreams and aspirations.
Core program components	The program starts by assessing the family's needs, issues, challenges, strengths and resources, before the development of an individualised service plan. Initial focus is on developing the relationship between worker and family, to enable collaborative problem solving of family challenges. Families are supported via teaching, mentoring and advice to assist them to recognise and use their strengths and resources.

	Content includes: • physical, social and emotional wellbeing of infants and children and healthy child development • information about child health and safety e.g. timely medical visits, immunisation compliance, wellbeing checklists and home safety. • parenting education including parental sensitivity, positive parenting and non-punitive parenting. • support for parental physical and mental health • supporting participation in early childhood education services • information about economic and material wellbeing (budgeting, employment), positive adult relationships and crisis management. • care and protection issues • child and home safety education and monitoring • smoke cessation to enable a smoke free home environment • family wellbeing • advocacy, home skills and help with relationship issues • support for family violence and addictions • crisis intervention work Through delivery of the following programs: • Listen, Love, Play • Triple P Positive Parenting Programme • Getting Ready For School • Breastfeeding Group • The HUB – a base where families can access support services
Associated outcomes	• Improved child safety and physical wellbeing • Reduced child abuse or neglect • Better child education outcomes • Improved parenting skills • Better long term outcomes relating to agency contact for abuse or neglect • Better long term behavioural outcomes for the children
Evidence of effectiveness	These outcomes have been demonstrated in one RCT with a three and nine year post RCT follow up (see Fergusson et al., 2005; Fergusson et al., 2012; Macvean et al 2013)
Effect size or measures of impact	At 36 months the measure of exposure to child abuse and neglect differed from 11.7% of control to only 4.4% of the Early Start group, producing a small effect size for this comparison (*d* = .26). At 36 months the Early Start group exhibited fewer externalising and internalising behavioural problems producing a small effect

	size of *d* = .24. By the nine year follow up the Early Start group displayed a small to medium effect for Hospital attendance for accidental injury (*d* = .29), Severe/very severe physical assault by any parent (*d* = .29), and improved parenting competence (*d* = .25).
Analysis of evidence of effectiveness	This program is supported by at least one RCT on several key child, parent, and family outcomes, with maintenance of some effects demonstrated up to nine years post intervention and was rated as an 'Emerging' program by The Parenting Research Centre. (Macvean et al 2013)
Training and accreditation requirements	Family Support Workers have professional qualifications with backgrounds in nursing, social work, early childhood education, teaching or other related fields. No information on further training was located.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice. The program is also likely to be acceptable to clients as its flexible delivery will cater to individual family's needs and diverse cultural backgrounds.
Use in Australia	No
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	The program is flexible and culturally sensitive with individualised delivery and is adaptable to Victorian requirements.
Anticipated challenges to implementation in Victorian context	None.
Indicative scale of implementation costs	No costing information was located.
Name of organisation holding Australian licence (if applicable)	N/A
References	Avellar, S.A., and Supplee, L.H. (2013). Effectiveness of home visiting in improving child health and reducing child

maltreatment. Pediatrics, 132, S90-99

Axford, N. and Barlow, J. (2013). What Works: An Overview of the Best Available Evidence on Giving Children a Better Start, Version 1.0. Totnes, Devon, UK: Social Research Unit at Dartington.

Dawe, S., and Harnett, P. (2007). Reducing potential for child abuse among methadone maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment*. 32, 381– 390

Fergusson, D.M., Grant, H., Horwood, L.J., and Ridder, E.M. (2005). Early Start Evaluation Report. Christchurch, NZ: Early Start Project Ltd.

Fergusson, D.M., Boden, X.X., and Horwood, L.J., (2012). Early Start Evaluation Report; Nine year follow-up. Christchurch, NZ: Early Start Project Ltd.

Macvean, M., Mildon, R., Shlonsky, A., Devine, B., Falkiner, J., Trajanovska, M., D'Esposito, F. (2013). Evidence review: An analysis of the evidence for parenting interventions for parents of vulnerable children aged up to six years (commissioned by the Families Commission of New Zealand), Parenting Research Centre, Melbourne.

Taylor, A., Carswell, S., Haldane, H. and Taylor, M. (2014). Toward a transformed system to address child abuse and family violence in New Zealand Literature Review – Part Two. Christchurch, New Zealand: Te Awatea Violence Research Centre, University of Canterbury.

http://earlystart.co.nz/index.html

Program name	SAFE ENVIRONMENT FOR EVERY KID (SEEK)
Originator/Organisation	University of Maryland School of Medicine
Aims and conceptual base	The aims of the program are to: • improve paediatric primary care, in order to better address prevalent psychosocial problems • Prepare paediatric primary care professionals (e.g., paediatricians, family medicine physicians, nurse practitioners and physician assistants) to identify, briefly assess and help address major risk factors for child maltreatment • Identify families with major risk factors for child maltreatment and facilitate help when indicated • Strengthen families, support parents, and promote children's health, development, and safety • Prevent child abuse and neglect
Target population / eligibility	Families with children aged birth to five years
Intervention level(s)	Families who function well Families who have some difficulties Families at risk of child maltreatment
Delivery mode	SEEK is typically conducted in a primary care setting serving children
Core program components	For child populations SEEK addresses food insecurity; harsh punishment; having a parent who is depressed, very stressed, and/or abusing substances; and being exposed to intimate partner violence For parent populations SEEK addresses depression, substance abuse, intimate partner violence, major parental stress, food insecurity, and use of harsh punishment SEEK provides health professional training to prepare child health professionals to assess and address problems such as parental depression. SEEK incorporates principles of Motivational Interviewing to more effectively work with parents in planning and engaging in services. The SEEK Parent Questionnaire (PQ) is a brief screening tool parents complete before seeing the health professional. Comprising 15 questions it takes two to three minutes to complete, either on paper or computer, and is presently available in English, Spanish, Chinese, and Vietnamese. User-friendly, one-page handouts are available for parents for all of the targeted problems. Handouts have space to list local

	resources and customise information. It is critical that professionals know what is available in the community to help address identified problems, such as substance abuse. SEEK recommends that medical professionals work with a mental health colleague, such as a social worker.
Associated outcomes	Fewer child protection service reports Fewer instances of possible medical neglect documented as treatment non-adherence Fewer children with delayed immunisations Less harsh punishment reported by parents Less psychological aggression reported by mothers Fewer minor physical assault reported by mothers
Evidence of effectiveness	The outcomes listed above have been demonstrated in one RCT with 12 month follow up (see Dubowitz, Feigelman, Lane, & Kim, 2009; Dubowitz, Lane, Semiatin, & Magder, 2012)
Effect size or measures of impact	The Dubowitz, Feigelman, Lane and Kim (2009) RCT reported that SEEK families had less contact with child protective services post intervention (odds ratio = 1.5) than the control group. SEEK families reported fewer instances of nonadherence to medical care (4.6% vs 8.4%; P = .05) and delayed immunizations (3.3% vs 9.6%; P = .002) than the control group. At 12 month follow-up there were small effects reported by SEEK mothers for less Psychological Aggression than controls (initial effect size = -0.16, 12-month effect size = -0.12) and fewer Minor Physical Assaults than controls (initial effect size = -0.16, 12-month effect size = -0.14).
Analysis of evidence of effectiveness	This program is supported by at least one RCT showing reduced child maltreatment with maintenance of effects demonstrated up to 12 months post intervention. It has received a scientific rating of two (out of five) from the California Evidence-Based Clearinghouse, where it is categorised as supported by research evidence. This study is limited by concerns regarding generalisability as 92% of participants were African American. A further limitation is the lack of true baseline data as families with prior child welfare involvement were not excluded from the study sample, blending results for primary, secondary, and tertiary prevention (intervention) samples.
Training and	Training is available online, electronically, via webinars or phone,

accreditation requirements	no manual. Initial training is two to -three hours in length. Ongoing training and support is offered, time is variable depending on needs and interest. Medical professionals should be licensed to practice as paediatricians, family medicine physicians, nurse practitioners, or physician assistants. Mental health professionals need at least a Master's degree in a relevant field and to be licensed to provide clinical services. Training Contact: Howard Dubowitz, MD, MS, FAAP University of Maryland School of Medicine hdubowitz@peds.umaryland.edu
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by at least two RCTs with 12 month follow up. The program is also likely to be acceptable to clients as it has been designed to be flexible regarding who does what in addressing problems. It is easily integrated into the usual care processes of the clinic and health professionals are able to choose their level of involvement depending on the parents' level of comfort. The SEEK Parent Questionnaire (PQ) is a brief screening tool parents complete before seeing the health professional. It has 15 questions, takes two to three minutes to complete, and is currently available in English, Spanish, Chinese, and Vietnamese. It can be completed on paper or computer. SEEK is funded by the US DHHS
Use in Australia	No
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	The program content is well set up and documented with training available. Program delivery is flexible and easily adaptable to Victorian clinics
Anticipated challenges to implementation in Victorian context	Gaining acceptance of the model from all the health professionals in the practice

Indicative scale of implementation costs	No cost information was located.
Name of organisation holding Australian licence (if applicable)	N/A
References	Axford, N. and Barlow, J. (2013). What works: an overview of the best available evidence on giving children a better start, Version 1.0. Totnes, Devon, UK: Social Research Unit at Dartington. Dubowitz, H., Feigelman, S., Lane, W., & Kim, J. (2009). Pediatric primary care to help prevent child maltreatment: the Safe Environment for Every Kid (SEEK) model. *Pediatrics, 123*(3), 858-864. Dubowitz, H., Lane, W. G., Semiatin, J. N., & Magder, L. S. (2012). The SEEK model of pediatric primary care: Can child maltreatment be prevented in a low-risk population? *Academic pediatrics, 12*(4), 259-268. Selph, S.S., Bougatsos, C., Blazina, I., & Nelson, H.D. (2013). Behavioral interventions and counseling to prevent child abuse and neglect: A systematic review to update the U.S. preventive services task force recommendation. *Annals of Internal Medicine 158*(3) 179-190. Sethi,m D., Bellis, M., Hughes, K., Gilbert, R., Mitis, F., & Galea, G. (2013). European Report on Preventing Child Maltreatment. World Health Organisation. Website: theinstitute.umaryland.edu/SEEK

Program name	SAFECARE
Originator/Organisation	National SafeCare Training and Research Center (NSTRC), Georgia State University School of Public Health
Aims and conceptual base	SafeCare is a home visiting program which aims to prevent child maltreatment. The California Evidence-Based Clearinghouse lists program goals as including to: • Reduce future incidents of child maltreatment • Increase positive parent-child interaction • Improve how parents care for their children's health and • Enhance home safety and parent supervision.
Target population / eligibility	Parents at-risk for child abuse or neglect and parents with a history of child abuse or neglect (child age: birth to five years).
Intervention level(s)	Families experiencing some difficulties Families at risk of child maltreatment Families receiving statutory child protection services
Delivery mode	18 to 20 weekly home visits, of 60 to 90 minutes duration
Core program components	Four modules which involve baseline assessment, intervention (training) and follow-up assessments to monitor change. Modules include: • Health (use of health reference material, prevention of illness, identification of symptoms of illness or injury, provide/seek appropriate treatment) • Home safety (identification and elimination of hazards) • Parent-child/parent-infant interaction (providing engaging activities, increasing positive reactions, preventing problem behaviour) • Problem solving and communication
Associated outcomes	• improved positive parenting[1] • improved health and safety[1] • reduced abuse/neglect[2]
Evidence of effectiveness	[1] These outcomes have been demonstrated in a pre/post test design study (Gershater-Molko, Lutzker & Wesch, 2003) [2] This outcome has been demonstrated in a matched comparison group design (Gershater-Molko, Lutzker & Wesch, 2002) and an RCT (Chaffin, Hecht, Bard, Silovsky & Beasley, 2012)
Effect size or measures of impact	A matched comparison study found that at 36 months post-intervention, 85% of families in the SafeCare group had no further reports for child abuse, compared to 54% in the treatment group (Gershater-Molko, Lutzker & Wesch, 2002)

	The RCT conducted by Chaffin et al (2012) reported significant main effects in relation to reduction of abuse and neglect across simple and more complex modelling approaches (hazard ratios = 0.74–0.83).
Analysis of evidence of effectiveness	This program is supported by RCT and matched comparison study-level evidence in relation to reduction of child abuse and neglect. It has received a scientific rating of two (out of five) from the California Evidence-Based Clearinghouse, where it is categorised as supported by research evidence. While the RCT conducted by Chaffin et al (2012) was a large-scale trial which followed cases for an average of six years, limitations included its cluster design (including a small number of clusters).
Training and accreditation requirements	To become certified SafeCare home visitors, practitioners must complete a four day workshop (32 hours), followed by observations of at least nine sessions by a certified SafeCare coach. Certified SafeCare home visitors can become coaches by attending an additional two day workshop (16 hours), followed by observations of at least six coaching sessions by a certified SafeCare Trainer. SafeCare coaches can become trainers by attending a three day workshop (24 hours), followed by observation of training and support of new home visitors by a trainer from the NSTRC.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by RCT evidence with demonstrated effects on reduction of child abuse reports. The program is also likely to be acceptable to clients.
Use in Australia	SafeCare has recently been adapted for use in Australia by the Parenting Research Centre (funded by the New South Wales Department of Family and Community Services). PRC and the NSTRC conducted a preliminary round of SafeCare training in 2015.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	SafeCare has been adapted to for use with particular groups in the US (i.e. at-risk fathers and the Latino community) and for use in Australia by PRC.

Anticipated challenges to implementation in Victorian context	None.
Indicative scale of implementation costs	The US Department of Health and Human Services Home Visiting Evidence of Effectiveness webpage indicates that the average cost of SafeCare per family is $2,275 (US). This includes personnel time for home visitors, coaches, and administrative support; office space; operating expenses; training costs (where training is conducted by NSTRC); and variable costs of SafeCare per family (such as materials, handouts, supplies for home safety).
Name of organisation holding Australian licence (if applicable)	PRC
References	Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in child protective services. Pediatrics, 129(3), 509-515. Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2002). Using recidivism data to evaluate Project Safecare: Teaching bonding, safety and healthcare skills to parents. Child Maltreatment, 7(3), 277-285. Gershater-Molko, R., Lutzker, J. R., & Wesch, D. (2003). Project SafeCare: Improving Health, safety and parenting skills in families reported for and at-risk for child maltreatment. Journal of Family Violence, 18(6), 377-386. Websites: http://safecare.publichealth.gsu.edu/ http://www.cebc4cw.org/program/safecare/detailed http://www.parentingrc.org.au/ http://homvee.acf.hhs.gov/Implementation/3/SafeCare-Estimated-Costs-of-Implementation/18/5

Program name	PROJECT SUPPORT
Originator/Organisation	Dr Renee McDonald and Dr Ernest Jouriles Southern Methodist University, Dallas Texas
Aims and conceptual base	Project Support was developed to target the impact of family violence on children. It aims to prevent or address behavioural problems, improve the mother-child relationship and reduce harsh parenting. It is based on cognitive behavioural therapy and attachment and relational theories.
Target population / eligibility	Children aged three to eight years who are at risk of or have been exposed to child abuse, neglect or family violence.
Intervention level(s)	Families at risk of child maltreatment Families receiving statutory child protection services
Delivery mode	Home-based weekly sessions of 60 to 90 minutes for up to eight months. The developers note that the intervention was not designed to have a set number of sessions, but should be delivered flexibly within the eight month period, covering the specified child management skills. Sessions were run by a therapist with assistance from a student.
Core program components	Project support includes two elements: (1) teaching mothers child behaviour management skills and (2) providing instrumental and emotional support to mothers. The first component involves providing mothers with direct instruction, practice and feedback in relation to increasing positive child behaviour, decreasing undesirable child behaviour, effective communication and relationship building. Specific topics include: • Attentive and non-directive play • Listening to and comforting your child • Contingent praise and positive attention • Appropriate instructions and commands • Contingent negative consequences for noncompliance and aggressive behaviour. The second component involves therapists providing emotional support and help to obtain material resources and social supports. Therapists also provide training in decision making and problem solving skills. Students accompanying therapists to home visits act as mentors to children while therapists work with mothers. Therapists also work together with mothers and one or more of their children to monitor the mother's mastery of skills.

Associated outcomes	• Improved ability to manage childrearing responsibilities • Reduced harsh parenting • Reduced ineffective parenting • Reduced child maltreatment reports • Reduced child conduct problems • Improved child happiness • Improved child social relationships • Lower levels of child internalising problems
Evidence of effectiveness	[1]These outcomes have been demonstrated in one RCT (see Jouriles et al, 2010; McDonald, Jouriles & Skopp, 2006).
Effect size or measures of impact	Jouriles et al (2010) reported that intervention mothers reported more rapid decreases on scores relating to: • perceived inability to manage childrearing responsibilities (large effect) • reports of harsh parenting (medium effect) • ineffective parenting (medium effect) compared to control families. They also reported that 5.9% of families in the Project Support condition had a subsequent referral to child protective services for child maltreatment, compared with 27.7% of control families, however this trend did not meet conventional levels of significance ($p = 0.086$). This may be attributable to the small sample size (n=35).
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child outcomes. It is listed as promising by the US National Institute of Justice's Crime Solutions. The Jouriles et al studies were conducted with a very small sample (35 families) and so findings may not be generalisable to the broader population.
Training and accreditation requirements	Jouriles et al (2010) describe therapists receiving 'extensive' training in the content and techniques of intervention. They indicate that this includes in-vivo practice and direct observation. Student assistants participated in a special university course that trained them to provide services to families affected by family violence and child maltreatment.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by RCT evidence with demonstrated effects on relevant child and parent outcomes. However, the developers note that most agencies working with this client group do not have the resources necessary to run such an intensive intervention and it may not be feasible without university involvement.

	The program is likely to be acceptable to clients.
Use in Australia	No.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	The program has been recently implemented in Sweden and so is likely adaptable for Victorian requirements if necessary.
Anticipated challenges to implementation in Victorian context	None other than the resourcing issues noted above.
Indicative scale of implementation costs	Cost information not located.
Name of organisation holding Australian licence (if applicable)	N/A
References	Jouriles, E., McDonald, R., Rosenfield, D., Norwood, W., Spiller, L., Stephens, N., Corbitt-Shindler, D. & Ehrensaft, M. (2010) Improving parenting in families referred for child maltreatment: A randomised controlled trial examining effects of Project Support. *Journal of Family Psychology*, 24(3), 328-338. McDonald, R., Jouriles, E. & Skopp, N. (2006). Reducing conduct problems among children brought to women's shelters: Intervention effects 24 months following termination of services. *Journal of Family Psychology,* 20(1):127–36. https://www.crimesolutions.gov/ProgramDetails.aspx?ID=60

Program name	**Child FIRST (Child and Family Interagency, Resource, Support and Training)**
Originator/Organisation	Dr Darcy I Lowell, Child First Inc
Aims and conceptual base	Child First is a home-based intervention aiming to reduce serious mental health concerns (for children and parents), child development and learning problems, abuse and neglect.
Target population / eligibility	Child First works with very vulnerable young children (prenatal to five years), and their families.
Intervention level(s)	Families at risk of child maltreatment Families receiving statutory child protection services Children living in out of home care
Delivery mode	Home visits are generally 60 to 90 minutes in length. Program duration is adjusted based on families' needs (average 6-12 months).
Core program components	Blueprints describes Child First as having two components: (1) a system of care to provide comprehensive, integrated services and supports to the child and family; and (2) a relationship-based approach to address the effects of trauma and adversity by enhancing nurturing, responsive parent-child relationships and promoting positive social-emotional and cognitive development. The content of program sessions are based on parental need, rather than a fixed curriculum.
Associated outcomes	• decrease in child behavioural problems[1] • improvement in child social skills[2] • improvement in child language development[2] • strengthening of the parent-child relationship[2] • decrease in parent stress[1] • improved parent mental health[3] • reduced language delays[4] • reduced likelihood of involvement in child protective services[4] • improved access to services[4] • decrease in child exposure to traumatic events (including family and non-family violence)[5] • decrease in child post-traumatic stress symptoms[5] • increase in child emotional protective factors[5] • improved teacher self-efficacy[5]
Evidence of	[1] Outcomes demonstrated in program evaluation and a pre-post

effectiveness	study (see http://www.childfirst.com/our-impact/) [2] Outcomes demonstrated in program evaluation (see http://www.childfirst.com/our-impact/) [3] Outcome demonstrated in program evaluation and an RCT (see http://www.childfirst.com/our-impact/) [4] Outcomes demonstrated in an RCT (see http://www.childfirst.com/our-impact/) [5] Outcomes demonstrated in pre-post studies (see http://www.childfirst.com/our-impact/)
Effect size or measures of impact	The Lowell et al (2011) RCT reported that Child FIRST families had less protective service involvement at three years post baseline (odds ratio = 2.1) relative to usual care. Effect sizes were not reported for the child welfare outcomes by Crusto et al (2008).
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes. Though only one RCT has been conducted, pre and post studies and ongoing program evaluation provide promising indications of program effectiveness. Child FIRST is rated as a 'promising' program by Blueprints, has received a positive preliminary review from Promising Practices and is categorised as an 'evidence-based early childhood home visiting service' on the US Department of Health and Human Services' Home Visiting Effectiveness website. Lowell et al (2011) note that limitations of their RCT included reliance on maternal report due to lack of funding for multimethod assessment during the trial. They stated it will be important to examine mechanisms through which reported effects were achieved. A further limitation was lack of formal analysis of intervention fidelity (though a fidelity checklist was used in clinical supervision).
Training and accreditation requirements	Training occurs over 12 months and involves five components: 1. Learning collaborative: a year-long process with four in-person sessions; 2. Trauma-informed Child-Parent Psychotherapy (CPP) training; 3. Online distance learning: guided web-based modules, video-conferencing, and readings; 4. Reflective clinical consultation from the State Clinical Director or an expert Child First Senior Clinical Consultant; and 5. Specialty training and an annual conference. All sites delivering Child First are required to meet accreditation

	criteria set by Child First Inc.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by an RCT and other research evidence with demonstrated effects on relevant child outcomes. The program is also likely to be acceptable to clients as a family-led approach to service delivery.
Use in Australia	No (does not appear to have been used in Australia)
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	As content of sessions is based on parental need, there is potential for adaptation to meet local requirements
Anticipated challenges to implementation in Victorian context	The program name would cause confusion in the Victorian child and family service system due to the existing Child FIRST referral platform.
Indicative scale of implementation costs	Program cost information is available from Blueprints: • start-up fee for new agencies $25,000 (US) • start-up training fees $16,000 (US) for Clinical Director/Supervisor; $10,000 (US) for each Clinician and Care Coordinator • $15,000 (US) annually for licencing plus $5,000 (US) for each Clinician Team (a Clinical Team includes a Clinician and Care Coordinator) • cost for assessments per team is estimated at a high of $900 (US) per year • estimated first year cost is $14,643 (US) to serve 60 families (note: costs decrease significantly in subsequent years) • average cost per family in Connecticut implementation is $8,000 per family.
Name of organisation holding Australian licence (if applicable)	N/A
References	Crusto, C.A. Lowell, D.I., Paulicin, B., Reynolds, J., Feinn, R., Friedman, S. R., & Kaufman, J. S. (2008). Evaluation of a Wraparound Process for Children Exposed to Family Violence. *Best Practices in Mental Health: An International Journal*, 4(1), 1-18 Lowell, D.I., Carter, A.S., Godoy, L., Paulicin, B., Briggs-Gowan, M.J. (2011). A Randomized Controlled Trial of Child First: A Comprehensive, Home-Based Intervention Translating Research

	into Early Childhood Practice. *Child Development*, 82(1), 193-208. Websites: http://www.childfirst.com/ http://www.blueprintsprograms.com/factsheet/child-first http://www.promisingpractices.net/program.asp?programid=283 http://homvee.acf.hhs.gov/Model/1/Child-FIRST/42/#Models-EvidenceofProgramModelEffectiveness

Placement & Reunification Outcomes

Best Practice

Program name	**TREATMENT FOSTER CARE OREGON FOR PRE-SCHOOLERS** (TFCO-P, formerly Early Intervention Foster Care (EIFC) & Multidimensional Treatment Foster Care for Pre-schoolers (MTFC-P))
Originator/Organisation	USA
Aims and conceptual base	TFCO-P is a treatment program focusing on three to six year old children in foster care. The program provides support to birth parents and carers with the aim of improving permanent placement outcomes and school readiness and reducing violent, antisocial behaviour.
Target population / eligibility	Children in foster care (birth to six years)
Intervention level(s)	Children living in out of home care
Delivery mode	The program targets a range of problems via a team approach delivered in home and community settings.
Core program components	Teams work intensively with the child, the foster parents, and potential permanent carers such as birth parents, adoptive relatives or nonrelatives through delivery of family therapy. Foster parents receive intensive training prior to placement, and are well supported after placement with daily phone calls, weekly home visits and support group meetings, and a 24-hour on-call crisis intervention. MTFC-P also includes a weekly therapeutic playgroup session to encourage school readiness.
Associated outcomes	• Placement stability.[1, 2, 3] • Better permanent placement outcomes regardless of the number of prior placements.[2] • Reduced violent, antisocial behaviour for the children.[3] • Improved attachment behaviours.[4] • Improved parenting skills.[1] • Reduced carer stress.[3]
Evidence of effectiveness	[1]These outcomes have been demonstrated in a 24 month post RCT follow up (see Macvean et al 2014) [2]These outcomes have been demonstrated in at least two RCTs

	(see Fisher, Burraston & Pears, 2005) [3]These outcomes have been demonstrated in at least one RCT (see Kinsey & Schlösser, 2013) [4]These outcomes have been demonstrated in at least one RCT with 12 month follow up (see Fisher & Kim, 2007)
Effect size or measures of impact	Permanent placement success rate of 90% (compared to control group rate of 64%) (Fisher, Burraston & Pears, 2005; Ivec, 2013). Mitigation against risks of multiple placements or permanent placement disruptions as illustrated by a lack of increased re-entry to foster care compared to control (Fisher, Burraston & Pears, 2005; Ivec, 2013). More than twice as many successful permanent placements at 24 month follow up (Ivec, 2013).
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on disruptive behaviour, higher levels of placement and placement stabilisation of pre-school aged foster children, with maintenance of effects demonstrated up to 24 months post intervention. It is rated two out of five by the California Evidence-Based Clearinghouse for Child Welfare (2009). A limitation of these studies is the lack of specific maltreatment profiles. This makes it unclear if the program is more or less effective on different types and severity of child maltreatment.
Training and accreditation requirements	There is a manual for implementation and training available for this program. Training typically runs for a total of 40 hours over five days. Training Contact is Gerard Bouwman TFC Consultants, Inc. phone: (541) 343-2388 x204 gerardb@tfcoregon.com
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an effective practice supported by multiple RCTs with 12 to 24 month follow up and demonstrated effects on relevant child outcomes Although this treatment model is very intensive and could be quite costly to run, it is likely to be acceptable to clients as it allows for the flexibility of keeping sibling groups together, and the nature of early intervention could prevent the need for further

	treatment.
Use in Australia	No, delivered and evaluated in the US
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	Program is tailored to individual needs of each family and is adaptable to Victorian requirements.
Anticipated challenges to implementation in Victorian context	This program may be expensive to implement given the intensive level of support provided.
Indicative scale of implementation costs	Cost information was not located.
Name of organisation holding Australian licence (if applicable)	NA
References	Fisher, P.A., Burraston, B., & Pears, K. (2005). The early intervention foster care program: Permanent placement outcomes from a randomized trial. *Child Maltreatment, 10*(1), 61–71. Fisher, P.A., & Kim, H.K. (2007). Intervention effects on foster preschoolers attachment related behaviours from a randomized trial. *Prevention Science, 8*, 161 – 170. Fisher, P. A., Kim, H. K., & Pears, K. C. (2009). Effects of multidimensional treatment foster care for preschoolers (MTFC-P) on reducing permanent placement failures among children with placement instability. *Children and Youth Services Review, 31*, 541–546. Ivec, M. (2013). *A necessary engagement: An international review of parent and family engagement in child protection*. Anglicare Tasmania. Kinsey, D., & Schlösser, A. (2013). Interventions in foster and kinship care: A systematic review. *Clinical Child Psychology and Psychiatry, 18*(3), 429–463. Macvean, M., Mildon, R., Shlonsky, A., Devine, B., Falkiner, J., Trajanovska, M., D'Esposito, F. (2013). Evidence review: An analysis of the evidence for parenting interventions for parents of vulnerable children aged up to six years (commissioned by the

	Families Commission of New Zealand), Parenting Research Centre, Melbourne. http://www.cebc4cw.org/program/treatment-foster-care-oregon-for-preschoolers/detailed http://www.tfcoregon.com/

Promising

Program name	FOSTERING HEALTHY FUTURES (FHF)
Originator/Organisation	Kempe Center for the Prevention and Treatment of Abuse and Neglect, University of Colorado Anschutz Medical Campus
Aims and conceptual base	FHF is a preventative program for pre-adolescent youth with a history of placement in out of home care. The program's primary aim is to increase child wellbeing. The California Evidence-Based Clearinghouse summarises the program's short and long term goals as follows: Short term • Promote healthy relationships with peers and adults • Promote positive attitudes about self and future • Promote skills for regulating behaviour and coping adaptively • Promote better mental health functioning Long-term • Reduce the likelihood of youth involvement in delinquency, substance use, and risky sexual behaviour • Reduce the likelihood of placement instability and restrictive placements • Reduce the likelihood of school failure and dropout • Reduce the likelihood of arrests and incarceration.
Target population / eligibility	Children aged nine to 11 years who have been placed in out of home care due to maltreatment.
Intervention level(s)	Children living in out-of-home care
Delivery mode	The intervention involves two components: skills groups and mentoring. Skills groups run for 90 minutes per week over 30 weeks. There are four boys and four girls in each group with a supervisor, a graduate student co-leader and a skills group assistant. Mentors meet with each child they mentor individually for two to four hours per week for 30 weeks. Children are paired with graduate student mentors studying social work, psychology or a related field. Mentors generally mentor two children each.
Core program components	Groups follow a manualised curriculum that includes cognitive-behavioural strategies targeted at helping children process their experiences related to placement in out of home care. Topics include emotion recognition, problem solving, anger management, cultural identity, change and loss and peer pressure. A multicultural emphasis is provided throughout sessions. Groups share a meal together to promote socialisation, affording children a chance to practice social skills under

	supervision. Mentoring activities and advocacy are tailored to the children's needs and strengths, following program guidelines.
Associated outcomes	• Improved mental health functioning • Reduced trauma symptomatology, including dissociative symptoms • Reduced mental health treatment • Improved quality of life • Fewer placement changes • Reduced residential treatment • Higher rates of permanency, including reunification and adoption
Evidence of effectiveness	Each outcome listed above has been demonstrated in one of two RCTs (Taussig & Culhane, 2010; Taussig et al, 2012)
Effect size or measures of impact	Taussig et al (2012) reported that children in the intervention group were 71% less likely to be placed in residential treatment than controls. Among children living in non-relative foster care at baseline, FHF children had 44% fewer placement changes. They were also 82% less likely to be placed in a residential treatment center and five times more likely to have attained placement permanency.
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child outcomes. It has received a scientific rating of two out of five from the California Evidence-Based Clearinghouse, where it is rated as supported by research evidence. It is rated as promising by the US National Institute of Justice's Crime Solutions and is classified as a program that 'works' by Child Trends. A five-county efficacy trial of FHF is currently underway in the US. A limitation of the RCTs that have been undertaken to date include differences in key variables between groups at baseline (though analyses controlled for these variables). Taussig & Culhane (2010) also note that children lost to follow up had lower intelligence quotients and more mental health problems than others.
Training and accreditation requirements	Group supervisors must complete three days of in-person training. Group supervisors and co-leaders complete an additional three hours of training before leading their first skills group and one to two hours per week of ongoing training throughout the intervention period. Mentors must complete 24 hours of training and orientation

	before being paired with children. They must participate in individual supervision, group supervision and a seminar in each week of the intervention, with team meetings every other week.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by RCT evidence with demonstrated effects on relevant child outcomes. However, the program is relatively resource-intensive. The program is likely to be acceptable to clients.
Use in Australia	No.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	The group component of the program is manualised and the manual could presumably be adapted for any local requirements. The mentoring component is responsive to the individual child and would not require adaptation, aside from any questions around frequency and duration of sessions, etc.
Anticipated challenges to implementation in Victorian context	This program is resource-intensive, which could be challenging for organisations wanting to pursue implementation. However, the staffing burden is eased by engaging graduate social work and doctoral students in program delivery.
Indicative scale of implementation costs	Information not readily accessible.
Name of organisation holding Australian licence (if applicable)	N/A
References	Taussig, H. N., & Culhane, S. E. (2010). Impact of a mentoring and skills group program on mental health outcomes for maltreated children in foster care. *Archives of Pediatrics and Adolescent Medicine*, 164, 739-746. Taussig, H. N., Culhane, S. E., Garrido, E., & Knudtson, M. D. (2012). RCT of a mentoring and skill group program: Placement and permanency outcomes for foster youth. *Pediatrics*, 130(1), 33-39. Websites: http://www.cebc4cw.org/program/fostering-healthy-futures-fhf/detailed http://www.ucdenver.edu/ https://www.crimesolutions.gov/ProgramDetails.aspx?ID=420

Program name	**HOMEBUILDERS (INTENSIVE FAMILY PRESERVATION SERVICE AND INTENSIVE FAMILY REUNIFICATION SERVICE)**
Originator/Organisation	Institute for Family Development, USA
Aims and conceptual base	Homebuilders is an intensive family program which aims to avoid children entering out of home care. Where children have entered out of home care, the program aims to reunify them with their birth families. Program goals are to reduce child abuse and neglect, family conflict, and child behaviour problems and to teach families the skills they need to prevent placement or successfully reunify with their children.
Target population / eligibility	Families with children (birth to 18) at risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities.
Intervention level(s)	Families receiving statutory child protection services Children living in out-of-home care
Delivery mode	Between three and five two hour contacts per week; an average of eight to 10 hours per week of face to face contact, with telephone contact between sessions, for an average of four to six weeks. Two aftercare 'booster sessions' (two and a half hours each) are available in the six months following referral.
Core program components	The Institute for Family Development lists the program's key program elements as follows: • Intervention at the crisis point (within 24 hours of referral) • Treatment in the natural setting (home or community) • Therapists on call 24 hours per day, seven days per week and families are given as much time as they need, when they need it • Service revolves around the immediate crisis, teaching the family the necessary skills to remain together • Therapists carry two to three cases at a time • Therapists use crisis intervention, motivational interviewing, parent education, skill building and cognitive behavioural therapy • Flexible assistance (wide range of help – from basic needs i.e. food, clothing, to issues including child development, parenting skills, etc).
Associated outcomes	• Avoidance of out of home care placement[1] • Increased reunification[2]
Evidence of effectiveness	[1] This outcome has been demonstrated in one RCT and three other published studies (see http://www.institutefamily.org/programs_research.asp and

	http://www.cebc4cw.org/program/homebuilders/detailed) [2] This outcome has been demonstrated in one RCT (see http://www.institutefamily.org/programs_research.asp)
Effect size or measures of impact	Blythe & Jayaratne (2002) reported that 93% of intervention children were living at home at 12 month follow up, compared with 43% of controls. The remaining 7% of intervention children were living in foster care or at a treatment centre, while 37% of remaining controls were living in foster care or a group home and 20% were living with relatives. Fraser et al (1996) reported that of 57 children who received an intervention based on Homebuilders, 55 (96.5%) re-entered their family home within the 90 day service period, compared to 32.1% in the control condition. Intervention children were reunified with their families after an average of 20.7 days, compared with 44.6 days for controls. At 15 month follow up, 70.2% of intervention children remained at home, compared with 47.2% of controls.
Analysis of evidence of effectiveness	There appears to be heterogeneity in implementation of Intensive Family Preservation Services, of which Homebuilders was the first example. The program described by Fraser et al (1996) was 90 days in length, which is longer than the current Homebuilders specifications (four to six weeks). Only a brief statement of results was located for the Blythe & Jayaratne (2002) RCT and so the length (and version) of the intervention utilised in that study is unknown. It is therefore unclear how the findings elaborated above apply to the current version of the program. A population-based retrospective study (Kirk & Griffith, 2004) concluded that Intensive Family Preservation Services (including Homebuilders) were shown to be effective in reducing out of home placements when model fidelity is high and the service is appropriately targeted. A literature review compiled for the New South Wales Government summarises the history of, and evidence for, Intensive Family Preservation Services, in depth (Tully, 2008). Homebuilders has received a scientific rating of two (out of five) from the California Evidence-Based Clearinghouse, where it is listed as supported by research evidence.
Training and accreditation requirements	Homebuilders requires five days of initial training, eight days of intermediate/advanced training and seven additional days of training for supervisors.

Acceptability	Homebuilders is a very resource-intensive intervention where therapists are available to families 24 hours per day, seven days per week. This intervention would likely only be acceptable to professionals if caseloads were low (two to three families per therapist, as recommended) and a high level of support was provided to workers.
Use in Australia	New South Wales has implemented an Intensive Family Preservation program which is effectively an extended, modified version of Homebuilders. The NSW program runs for six months up to one year. Intensive support is available within the first 12 weeks, followed up by 40 weeks of less intensive, but tailored support. These adaptations were made in response to an evaluation of the program in NSW, which suggested flexibility of duration was appropriate due to a lack of 'step down' support services for families who are no longer in crisis, but still require support (Intensive Family Preservation Program Guidelines, 2014). Tully (2008) indicates that Intensive Family Preservation has been implemented in Victoria as Families First in the past. However, Tully (2008) notes that an evaluation found there were a number of problems running the service. The evaluation by Campbell (1998; 2004 cited in Tully, 2008) revealed that Child Protection staff were unwilling to refer families to the program (especially when infants were involved), there were limited program vacancies and there were challenges in implementing the 24-hour service in Australian workplaces due to different industrial conditions compared to the US.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	Given the model has been adapted for implementation in NSW, it is highly likely to be suitable for local requirements. It is also highly likely that any further adaptations would be possible.
Anticipated challenges to implementation in Victorian context	None, other than the intensive resourcing issue raised above.
Indicative scale of implementation costs	Not available.
Name of organisation holding Australian licence (if applicable)	Licensing arrangements in NSW to be investigated.
References	Blythe, B. & Jayaratne, S., (2002), Michigan Families First Effectiveness Study. Available online at: www.michigan.gov/fia/o,

1607, 7-124-55458-7695-8366-21887-, oo.html

Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates of outcomes at one-year follow-up. *Children and Youth Services Review*, 18(4/5), 335-361.

Kirk, R.S. & Griffith, D.P., (2004), Intensive family preservation services: Demonstrating placement prevention using event history analysis. *Social Work Research*, 28(1), 5-15.

New South Wales Family & Community Services. (2014). Intensive Family Preservation Service Provision Guidelines. Available from http://www.community.nsw.gov.au/.

Tully, L. (2008). Literature review: Family preservation services. Research report. Available from: http://www.community.nsw.gov.au/

Websites:

http://www.institutefamily.org/programs_IFPS.asp

http://www.cebc4cw.org/program/homebuilders/detailed

Program name	**KEEPING FOSTER PARENTS TRAINED AND SUPPORTED (KEEP)**
Originator/Organisation	Dr Patricia Chamberlain
Aims and conceptual base	The aims of the program are to increase carers' use of positive reinforcement strategies as well as decrease the use of harsh discipline, and in turn reduce child problem behaviours and placement disruptions.
Target population / eligibility	Foster children between five and 12 years old.
Intervention level(s)	Children living in out of home care
Delivery mode	This program involves 16 weekly group sessions delivered to foster parents in community centres or churches. Group size ranges from three to 10 parents. Sessions are conducted by a trained facilitator and cofacilitator, run for 90 minutes and cover behaviour management methods. In addition to group sessions, home visits are made when parents miss a session (20%).
Core program components	Program components include information on increasing the use of positive reinforcement, consistent use of non-harsh discipline methods (e.g. brief time-outs, brief removal of privileges), and the importance of monitoring children's whereabouts and peer associations. Strategies for avoiding power struggles, managing peer relationships and improving performance at school are also covered. Group discussion, role-play and videotaped recordings are used to illustrate primary concepts. Home practice assignments are also utilised to assist with implementation of behavioural procedures taught.
Associated outcomes	• Higher likelihood of reunification among intervention children • Mitigated risk of previous multiple placements
Evidence of effectiveness	The outcomes noted above have been demonstrated in one RCT involving 700 foster families, 30% of whom experienced a change in placement during the program evaluation period of 200 days.
Effect size or measures of impact	Children in the intervention group were almost twice as likely as those in the control group to experience a positive exit (e.g. reunification with parents, kinship placement or adoption) by the end of the intervention period. Although the intervention had no effect on negative exits (e.g. moves to another foster placement, restrictive care environments

	such as psychiatric wards or juvenile detention centres, or runaways), it moderated the effect of prior placements on negative exits. That is, whereas the number prior placements was associated with a 15% increase in risk of negative exits for each additional placement for children in the control group, the effect of prior placements was non-significant for those in the intervention group.
Analysis of evidence of effectiveness	This program is supported by one RCT examining positive and negative exits from care. Follow-up was limited to 200 days post-baseline assessment (6.5 months). Reasons for exit were obtained from foster carers (and may have differed from those recorded by case-workers or children).
Training and accreditation requirements	Training involves attendance at 16 group-based sessions and contributes credit to licencing requirements for foster carers in the US.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by one RCT with demonstrated effects on child placement outcomes. The program is also likely to be acceptable to clients. Price et al (2008) report that 80% of parents attended at least 81% of group sessions (12+) and 75% of parents attended 90% (14+) of sessions or more. Efforts to maintain involvement included provision of childcare, credit towards foster care licencing requirements, and reimbursement ($15US) for travel costs. In terms of recruitment, Price et al report that 62% of eligible families enrolled in the trial, and of the 38% that did not, the most common reason for declining was being too busy with work or children (50%). The next most common reason was disinterest (43%). It is worth noting that the sample was ethnically diverse, including participants from African American, Latino, White, Asian American, Native American and mixed ethnic backgrounds.
Use in Australia	No
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation	Program components are likely to be adaptable to local

to local requirements	requirements.
Anticipated challenges to implementation in Victorian context	As experienced in the US, and with many other parenting programs, engaging all eligible families may be challenging.
Indicative scale of implementation costs	A cost-benefit analysis was not conducted. However, Price et al (2008) note that the costs associated with implementing the intervention are likely to be offset by the costs associated with the consequences of externalizing behaviour problems, which affect a large proportion of children in foster care. They note costs associated with multiple placement disruptions, use of mental health services, and possible placement in residential care.
Name of organisation holding Australian licence (if applicable)	N/A
References	Price, J.M., Chamberlain, P., Landsverk, J., Reid,J.B., Leve, L.D., & Laurent, H. (2008). Effects of a foster parent training intervention on placement changes of children in foster care. Child Maltreatment, 13, 64-75. DOI:10.1177/1077559507310612

Program name	**TREATMENT FOSTER CARE OREGON – ADOLESCENTS (TFCO-A)** *(Previously named Multidimentional Treatment Foster Care – Adolescents)* Evidence supporting the effectiveness of this program is stronger in the area of improving child social and emotional wellbeing, particularly with respect to behavioural problems, delinquency and crime. As such, the detailed entry is presented under the Social and Emotional Wellbeing section.

Program name	FOSTERING INDIVIDUALISED ASSISTANCE PROGRAM (FIAP)
Originator/Organisation	Dr Hewitt B Clark and colleagues, Department of Child and Family Studies, University of South Florida
Aims and conceptual base	FIAP provides individualised wraparound support to foster children with emotional and behavioural problems, and their families. The primary aim of the program is to improve permanency of placements (i.e. reunification, adoption, independent living) and emotional and behavioural adjustment.
Target population / eligibility	Children (seven to 15 years) in foster care with emotional and behavioural problems, and their families (birth, adoptive and/or foster families, depending on circumstances)
Intervention level(s)	Children living in out of home care.
Delivery mode	FIAP wraparound teams (composed of as many relevant adults in the child's life who are willing participate) meet monthly, depending on the changing needs of each child and the immediate circumstances. FIAP family specialists lead team meetings, with the aim of transitioning this responsibility to a parent or other adult with a consistent role in the child's life as the program progresses and then transitions to closure. Intensive, specialised services and supports are also provided in the child's home or in the community, depending on needs.
Core program components	FIAP family specialists act as family-centred clinical case managers and home-based counsellors, who collaborate with other caseworkers and significant adults in the child's life (i.e. foster parents, birth parents, teachers, therapists, etc) to implement: • Strength based assessment • Life domain planning • Clinical case management • Follow-along supports and services These elements are described in detail by Clark et al (1996). Essentially, family specialists lead wraparound care teams for children and build the capacity of adults in their lives to carry out this function into the future so that children are more supported and families are better connected. They also work directly with children to provide child counselling, family preservation interventions and family therapy, depending on needs.
Associated outcomes	• Fewer placement changes • Increased likelihood of placement permanency • Less time as a runaway • Improved emotional/behavioural adjustment
Evidence of	These outcomes have been demonstrated in one RCT (Clark et

effectiveness	al, 1996).
Effect size or measures of impact	No effect size was reported for the finding that FIAP children experienced fewer placement changes compared to controls. From entry into the study until approximately two and a half years later, FIAP children experienced a mean of 2.2 placement changes per year, compared to 4.9 in the control group. Clark et al (1996) reported that FIAP children were significantly more likely than controls to have been placed in a permanency home following conclusion of the study (53.7% of FIAP children, compared with 37.2% of controls).
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child outcomes. It is classified as a program that 'works' by Child Trends and was identified as 'promising' by Shlonksy et al (2013). Clark et al (1996) note that limitations of their research included the evolving design of the intervention and issues with program fidelity due to variations across family specialists and supervisors. They also note several sources of confound, including reorganisation of the foster care system during the study period and delays in securing permanency plans through the system and the courts, as well as enhancement of "standard practice" during the study.
Training and accreditation requirements	Specific training information was not available, however it is assumed that relatively extensive training is required given the broad and intensive nature of the family specialist role.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by RCT evidence with demonstrated effects on relevant child outcomes. However, the program is relatively resource-intensive and is not 'proven'. Implementation would likely need to be accompanied by extensive monitoring and evaluation to consider its effectiveness. The program is likely to be acceptable to clients.
Use in Australia	No.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	As an intervention that focuses on the child's circumstances, it is assumed that the program is readily adaptable to local

	requirements.
Anticipated challenges to implementation in Victorian context	None, other than high resourcing (including supervision) requirements.
Indicative scale of implementation costs	Not located.
Name of organisation holding Australian licence (if applicable)	N/A
References	Clark, H. B., Lee, B., Prange, M. E., McDonald, B. A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child and Family Studies*, 5,39-54. Shlonsky, A., Kertesz, M., Macvean, M., Petrovic, Z., Devine, B., Falkiner, J., D'Esposito, F., and Mildon, R. (2013). Evidence review: Analysis of the evidence for out-of-home care. East Melbourne, Victoria: parenting Research Centre. Websites: http://www.childtrends.org/?programs=fostering-individualized-assistance-program-fiap

Program name	**MULTISYSTEMIC THERAPY FOR CHILD ABUSE AND NEGLECT (MST-CAN)**
	For details, see the Social and Emotional Wellbeing Outcomes section

Social and Emotional Wellbeing, Health and Trauma Recovery Outcomes

Best Practice

Program name	THE INCREDIBLE YEARS
Originator/Organisation	Program Developer/Owner – Carolyn Webster-Stratton, Ph.D. Incredible Years, Inc. Information contact – Lisa St George, Administrative Director Incredible Years, Inc. 1411 8th Avenue West, Seattle, WA 98119 USA. Phone: 888-506-3562 or 206-285-7565. lisastgeorge@comcast.net www.incredibleyears.com
Aims and conceptual base	The Incredible Years is a program where counsellors and therapists treat children with conduct problems, ADHD, and internalising problems in small group settings by enhancing social competence, positive peer interactions, conflict management strategies, emotional literacy, and anger management. The Incredible Years consists of three training programs, child, parent and teacher, enabling a comprehensive treatment model.
Target population / eligibility	Families with children up to 12 years who meet the criteria for oppositional defiant disorder and/or ADHD.
Intervention level(s)	Families who have some difficulties, Families at risk of child maltreatment Families receiving statutory child protection services
Delivery mode	Between nine to 22 weekly sessions of two hours duration, depending on the program (child, parent or teacher). Trained facilitators use videotaped scenes to encourage group discussion, problem-solving, and sharing of ideas.
Core program components	Child training consists of small group therapy sessions where two therapists work with six to seven children. Focus is on social skills, conflict resolution, empathy-building, problem solving and cooperation. Teachers and parents receive weekly updates on the concepts covered, and are provided with strategies to reinforce the skills taught. Children are assigned homework to complete with their parents. Weekly good behaviour charts are provided for parents and teachers to complete. Parent training consists of three programs targeting key developmental stages. The Baby and Toddler Program consists of nine to 13 sessions and provides training appropriate for children from birth to two and a halfyears. The Preschool Program consists of 18 to 20 sessions and provides training appropriate for children from three to five years, and the School Age Program runs for 12 to 16 (or more) sessions and provides training appropriate for children from six to 12 years.

	These parent programs focus on developmentally appropriate parenting skills which are known to reduce behaviour problems while promoting children's social competence, emotional regulation and academic skills. The BASIC program contains a home visiting component for parents mandated to enrol due to child abuse or neglect. (Carnochan et al 2014) Program materials include a therapist manual, DVDs, workbooks for home activities, problem solving books, and case vignettes Optional extra program materials are available e.g., puppets and magnets.
Associated outcomes	• Increased parental positive affect (e.g. praise and reduced criticism and negative commands).[1] • Increased effective parental limit-setting and monitoring of children, and decreased use of violent discipline techniques.[1] • Reduced parental depression and increased parental self-confidence.[1] • Increased positive family communication and problem-solving.[1] • Reduced conduct problems in children's interactions with parents.[1] • Increased child positive affect, social competence and compliance.[1] • Benefits for externalising behaviour of children from 2-9.[1] • Benefits for parenting and parent mental health.[1, 2] • Increased child social and emotional competence with peers in the classroom.[3] • Increased child problem solving skills.[3] • Reduced child behaviour problems.[3] • Increased academic readiness and cooperation with teachers.
Evidence of effectiveness	[1]These outcomes have been demonstrated in 12 RCTs of the parenting programmes by Webster-Stratton and colleagues (e.g. Webster-Stratton, 2006; Webster-Stratton & Reid, 2003) and multiple independent RCTs conducted in Internationally (e.g., Patterson et al, 2002; Scott et al, 2001; Hutchings et al, 2007; Gardner et al, 2006) (see http://www.blueprintsprograms.com) [2] These outcomes have been demonstrated in multiple RCTs with 12 and 24 month follow ups (see http://www.blueprintsprograms.com) [3] These outcomes have been demonstrated in three RCTs of the child treatment programme with diagnosed children by Webster-Stratton and colleagues, and at least one independent RCT (see http://www.blueprintsprograms.com)
Effect size or measures of impact	A meta-analysis of over 50 studies (Menting et al., 2013) demonstrated small average effects for both child disruptive and prosocial behaviour (d=.27,.23, respectively) Child Program:

	70.0 to 80.8% of mothers reported positive changes in their child's behaviour post intervention, compared with 27.3% in the control group (Webster-Stratton and Hammond, 1997). 68.2 to 71.4% (treatment depending) of mothers showed a reduction of criticism (by at least 30%) post intervention, compared with 27.8% of the control group (Webster-Stratton and Hammond, 1997). 60.0 to 95.0% (treatment depending) of children showed a reduction in deviant behaviours (by at least 30%) at one year post intervention, compared with 27.8% of the control group (Webster-Stratton and Hammond, 1997). Parent Program: Parent training demonstrated effect sizes ranging from small to medium (d = .26, .47) for parent reported child depression and anxiety symptoms. Parent confidence and competence improved greatly, with a large effect size reported (d = .84) Child plus Teacher Program: With the inclusion of Teacher Training (TT), Webster-Stratton, Reid, and Hammond (2004) reported reductions in conduct problems at home in 81.3 to 84.6% (treatment depending) of the children compared to 40% of control, and reductions in child negative behaviour in 69.2 to 85.0% (treatment depending) compared to 36% control. All treatment conditions reported improvements in conduct problems at school in 45.5 to 70.6% of children compared to 8.3% control (teacher observations) and in 53.8 to 83.3% of children compared to 20% control (classroom observations) (Webster-Stratton, Reid, & Hammond, 2004). Child plus Parent plus Teacher Program: The combination of parent, child and teacher training showed moderate to large main effects in eight out of nine domains ranging from Mother positive parenting (*d* = .46) to Father negative parenting (*d* = .77) (Webster-Stratton, Reid, & Hammond, 2004). Webster-Stratton, Reid, & Stoolmiller (2008) reported improvements in teacher behaviour, teacher management skills and teaching style, with effects ranging from medium (for harsh/critical, inconsistent/permissive, and warm/affectionate outcomes) to large (on social/emotional teaching and effective discipline). Effects for teacher harsh/critical behaviour were very large indicating the more critical the teacher was initially, the more their score improved post intervention.
Analysis of evidence of effectiveness	This program is supported by multiple RCTs on multiple child and parent

	outcomes at home and at school, with maintenance of effects demonstrated up to two years post intervention. The Incredible Years is rated as a 'promising' program by Blueprints, and as 'Proven' by Promising Practices. Although there have been a large number of studies of the parent program, few have been able to report on sustainability one year beyond treatment. Dropout rates for treatment groups were high and most long-term studies were unable to follow-up the data. It is difficult to determine the long term effects of the child program as one and two-year follow-up assessments did not include the control group. Furthermore, generalisability is questionable as samples were primarily white, two-parent, middle-income families, with motivation to bring their children to a clinic for treatment.
Training and accreditation requirements	A three day workshop focuses on ways to promote children's emotional literacy, anger management, appropriate conflict management strategies, expected classroom behaviours, and positive social skills or friendship behaviours with other children and adults. The workshop covers methods for working with small groups of children and is appropriate for use with children with behaviour problems as "pull out" programs conducted in mental health centres or in schools. The certification for the program requires completion of: • Three-day approved training workshop from a certified trainer for the Small Group DINA program. • Completion of two groups, minimum. • Feedback from a mentor or trainer - supervision, group consultation, coaching, or phone consultation. • Peer review of groups by co-facilitator using the peer-evaluation form. • Self-evaluation of two groups using the self-evaluation form. • Trainer review of groups or DVDs of groups (two sessions). • Session checklists for each session, showing the minimal number of sessions delivered and core vignettes shown. • Submission of parent final evaluations from two groups. • Background questionnaire. • Application. • Two letters of recommendation from other professionals who are able to speak to facilitator background and work with this program. Once a person has become certified as a group facilitator, they are eligible to be invited to become trained as a peer coach and certified mentor of group facilitators. Becoming a mentor permits the person to train other facilitators in their own agency and to provide mentoring and supervision of their groups.

Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by multiple RCTs with two year follow up and over 30 years of empirically validated training methods. The program is also likely to be acceptable to clients as it is already used within Australia and worldwide in schools and mental health centres and has been shown to work across cultures and socioeconomic groups. Effectiveness has been shown to increase as program engagement increases, and has been demonstrated for low-income families.
Use in Australia	Yes
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	The program has well established, standardised processes for training and support, and can be delivered through existing community centres with minimal set up.
Anticipated challenges to implementation in Victorian context	None
Indicative scale of implementation costs	Program cost information is available from Blueprints: Estimated year-one cost example = $38,710.80 US Initial cost approximately $2,150.60 US per child Based on: • a community-based organisation offering the program (rent not included) • three groups of 6 children (total 18 children participating) • 2 program leaders per group, • 20 sessions per group • Costs assume 6 different group leaders or teachers (if the same two group leaders ran all three groups and shared a set of program DVDs then costs will be reduced) Subsequent groups in future years are estimated to cost less (approx. $1,117.95 US), assuming no additional group leader or teacher training and re-use of program DVDs and manuals.
Name of organisation holding Australian licence (if applicable)	N/A
References	Axford, N., and Barlow, J. (2013). What works: An overview of the best available evidence on giving children a better start, Version 1.0. Totnes,

Devon, UK: Social Research Unit at Dartington.

Carnochan, S., Rizik-Baer, D., and Austin, M.J. (2013). Preventing the recurrence of maltreatment. *Journal of Evidence-Based Social Work. 10*(3) 161-178.

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Powell, D., & Dunlap, G. (2009). *Evidence-based social-emotional curricula and intervention packages for children 0-5 years and their families: Roadmap to effective intervention practices.* Tampa, Florida: University of South Florida, Technical Assistance Center on Social Emotional Intervention for Young Children.

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Webster-Stratton, C., and Hammond, M. (1997). Treating children with early-onsent conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology 65*(1), 93–109.

Webster-Stratton, C., Reid, M.J., & Stoolmiller, M. (2008). Preventing conduct problems and improving school readiness: An evaluation of the Incredible Years Teacher and Child Training Program in high risk schools. *Journal of Child Psychology and Psychiatry, 49(5),* 471-488.

http://www.blueprintsprograms.com/factsheet/incredible-years-child-treatment

http://www.promisingpractices.net/program.asp?programid=134#findings

Program name	TUNING IN TO KIDS (TIK)
Originator/Organisation	Dr Sophie Havighurst and Ann Harley Mindful, Centre for Training and Research in Developmental Heath at the University of Melbourne
Aims and conceptual base	TIK aims to teach parents skills in emotion coaching to help them recognise, understand and respond to children's emotions in an accepting, supportive way. With this support, children are enabled to better understand and manage their emotions. Specialised versions of the program are also available, including Tuning into Teens, Dads Tuning into Kids, Tuning into Toddlers and Trauma-focused Tuning into kids.
Target population / eligibility	TIK targets all parents, with particular benefits for parents who avoid, dismiss or react with harsh criticism and punishment to children's expression of emotions. Trauma-focused TIK targets parents/carers of children who have experienced complex trauma.
Intervention level(s)	• Families who function well • Families who have some difficulties • Families at risk of child maltreatment • Families receiving statutory child protection services • Children living in out-of-home care
Delivery mode	Between six and eight weekly sessions of two hours duration, with an additional one or two follow up booster sessions at bimonthly intervals. Delivered in a group format with a recommended size of up to six families for higher need/clinical participants and up to 14 for a community group.
Core program components	The California Evidence-Based Clearinghouse describes the program as coaching parents to develop stronger relationships with their children by learning how to: • Become more emotionally responsive • Connect with children when their children are emotional and to use this as an opportunity to teach emotional awareness, understanding and regulation rather than as a time to withhold attention or punish • Reflect on the influences of their family of origin on their parenting • Understand the impact of emotionally dismissive versus emotion coaching parenting styles • Manage strong emotions such as sadness, anxiety, and anger in themselves and their children • Solve problems and negotiate limits around children's behaviour • Consider their own well-being and take care of themselves.

Associated outcomes	• Increased/improved child emotion coaching by parents[1] • Parents less critical and dismissive of children's emotional expression[2] • Improved child behaviour[2] • Improved parent emotion awareness and regulation[3] • Improved child emotional knowledge/understanding[4] • Increased parental empathy[5]
Evidence of effectiveness	[1] This outcome has been demonstrated in four RCTs and one interrupted time series study (see http://www.cebc4cw.org/program/tuning-in-to-kids-tik/detailed) [2] These outcomes have been demonstrated in five RCTs and one interrupted time series study (see http://www.cebc4cw.org/program/tuning-in-to-kids-tik/detailed) [3] This outcome has been demonstrated in one RCT (see http://www.cebc4cw.org/program/tuning-in-to-kids-tik/detailed) [4] This outcome has been demonstrated in three RCTs (see http://www.cebc4cw.org/program/tuning-in-to-kids-tik/detailed) [5] This outcome has been demonstrated in two RCTs (see http://www.cebc4cw.org/program/tuning-in-to-kids-tik/detailed)
Effect size or measures of impact	Havighurst et al (2015) reported a medium sized effect for the reduction in emotion dismissing in the intervention group parents compared with controls.
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes across multiple studies conducted at various sites. It has received four out of four stars from Kids Matter in relation to evidence of effectiveness and a scientific rating of two (one to five scale) from the California Evidence-Based Clearinghouse where it is listed as supported by research evidence. A pilot study of the trauma-focused version of the program has been undertaken and the relevant publication is currently under review. Limitations of studies conducted include relatively small sample sizes, reliance on self-report and other sample considerations for particular studies (ethnic make-up and attrition rates). For example Havighurst et al (2015) note that their sample was largely ethnically homogeneous and attrition was greater than 15% (primarily for parent follow-up questionnaires in both groups, though there were significantly fewer child assessments and teacher questionnaires for control children at follow up).
Training and accreditation requirements	Two days training (total 14 hours)
Acceptability	This program has been extensively implemented and evaluated

	in the Australian context and so is likely to be highly acceptable to Victorian practitioners and clients.
Use in Australia	Developed in Melbourne, used in Australia and elsewhere.
Perceived 'fit' with the Victorian child & family service system	Already used in Victoria
Potential for adaptation to local requirements	Already used in Victoria
Anticipated challenges to implementation in Victorian context	Already used in Victoria
Indicative scale of implementation costs	Kids Matter list program costs as including photocopying/printing parent handouts, venue hire, refreshments and program manuals ($175 excluding GST, posted within Australia for $15). Training for certification as a Tuning into Kids facilitator costs $745 and is delivered nationally.
Name of organisation holding Australian licence (if applicable)	Mindful, Centre for Training and Research in Developmental Heath at the University of Melbourne
References	Havighurst, S. S., Duncombe, M. E., Frankling, E. J., Holland, K. A., Kehoe, C. E., & Stargatt, R. (2015). An emotion-focused early intervention for children with emerging conduct problems. *Journal of Abnormal Child Psychology*, 43(4), 749-760. Websites: http://www.tuningintokids.org.au/ http://www.cebc4cw.org/program/tuning-in-to-kids-tik/detailed http://www.kidsmatter.edu.au/early-childhood/programs/tuning-kids

Program name	**TREATMENT FOSTER CARE OREGON – ADOLESCENTS (TFCO-A)** *(Previously named Multidimentional Treatment Foster Care – Adolescents)*
Originator/Organisation	Dr Patricia Chamberlain Treatment Foster Care Consultants Inc
Aims and conceptual base	TFCO-A is a foster care treatment program for adolescents with severe emotional and behavioural problems and/or delinquency. As listed by the California Evidence-Based Clearinghouse, goals of TFCO-A are to: • Eliminate or reduce youth problem behaviours • Increase developmentally appropriate normative and prosocial behaviour in youth • Transition youth to a birth family or lower level aftercare resource • Improve youth peer associations • Improve parent-child interaction and communication • Improve youth coping and social skills • Improve behaviour in school and provide academic support.
Target population / eligibility	Adolescent boys and girls (12-17 years) with severe emotional and behavioural problems and/or delinquency.
Intervention level(s)	Families at risk of child maltreatment Families receiving statutory child protection services Children living in out-of-home care
Delivery mode	Adolescents are placed with a trained TFCO-A (treatment) family for six to nine months.
Core program components	Treatment families receive daily telephone contact and the adolescent's behaviour is tracked using a Parent Daily Report system. Adolescents lose and earn points based on their behaviour. Adolescents are also assigned to an individual therapist who they see on a weekly basis for support and coaching in social skills. In addition, the program includes a family therapy component with the adolescent's birth family to prepare for their return home and to help families manage the adolescent's behaviour. Adolescents are able to visit birth families once they reach a certain level in the program (in relation to the point system). Finally, adolescents have a 'school card' which teachers sign off to indicate attendance, behaviour and homework completion.

	Once adolescents finish the program and return home, families receive aftercare support. Group sessions are available for parents and such aftercare services generally last one year.
Associated outcomes	• Fewer behavioural problems/improved behaviour[1] • Fewer criminal referrals[2] • Fewer self-reported delinquent acts, and violent or serious crimes[3] • Spent more days living with their families[3] • Fewer days in locked settings[1] • Less delinquency[1] • Fewer associations with delinquent peers[3]
Evidence of effectiveness	[1] Outcomes demonstrated in two RCTs (see http://www.cebc4cw.org/program/treatment-foster-care-oregon-adolescents/detailed) [2] Outcome demonstrated in three RCTs (see http://www.cebc4cw.org/program/treatment-foster-care-oregon-adolescents/detailed) [3] Outcomes demonstrated in one RCT (see http://www.cebc4cw.org/program/treatment-foster-care-oregon-adolescents/detailed)
Effect size or measures of impact	Chamberlain and Reid (1998) reported that compared to controls, boys who received the intervention spent nearly twice as much time living with parents or relatives during the 12 months after program enrolment.
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child outcomes, over multiple studies. It has received a scientific rating of one from the California Evidence-Based Clearinghouse where it is listed as well-supported by research evidence and is a certified model program according to Blueprints. Early studies focused on evaluating the program in populations of adolescent boys, but studies have since been conducted to show effects for girls. RCTs have mostly been conducted in the US, however one RCT showed positive treatment effects in Swedish youth (Westermark, Hansson & Olsson, 2011). An RCT conducted in the UK did not show evidence that the intervention resulted in better overall outcomes compared to usual care (Green et al, 2014). However, Green et al (2014) cite a number of limitations, including imbalance in the observational cohort (and therefore the analysis), issues with how participants were randomised and lack of follow up.
Training and accreditation	TFC conducts training in Eugene, Oregon. It runs for 40 hours over five days.

requirements	
Acceptability	This is a very intensive model which relies on trained treatment families who undertake extensive monitoring and involvement in facilitating the adolescents' behaviour change. The intervention runs for 24 hours a day, seven days per week and is therefore highly resource intensive. This is compounded by the fact that it is implemented over a long period (six to nine month intervention, plus follow up for 12 months).
Use in Australia	No
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	The program has a specific 'point system' for behaviour which is standard and any adaptation to this will affect program fidelity.
Anticipated challenges to implementation in Victorian context	Issues with resourcing identified above.
Indicative scale of implementation costs	Blueprints estimation of costs to start a TFCO program serving 10 families (assuming 80% occupancy): • Certification cost $39,500 (US) • Staff-Supervisor 1FTE Masters Clinician $75,000 (US) • Family Individual Therapist .5 FTE $30,000 (US) • Foster Parent Recruiter/Support Person .75 FTE $45,000 (US) • Fringe at 30% $45,000 (US) • Psychiatric Consultation $20,000 (US) • Foster Parent Stipends @ $2500/month $240,000 (US) • Overhead @ 20% of Staff Cost $39,000 (US) • Total Year One Cost $533,500 (US) • Cost per youth for stay of 7.5 months (average) $43,242 (US)
Name of organisation holding Australian licence (if applicable)	N/A
References	Chamberlain, P., & Reid, J. B. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology*, 66(4), 624-633. Green, J. M., Biehal, N., Roberts, C., Dixon, J., Kay, C., Parry, E., Rothwell, J., Roby, D., Kapadia, D., Scott, S. & Sinclair, I. (2014). Multidimensional Treatment Foster Care for Adolescents in English care: Randomised trial and observational cohort evaluation. *The British Journal Of Psychiatry*, 204(3), 204-214.

	Westermark, P. K., Hansson, K., & Olsson, M. (2011). Multidimensional Treatment Foster Care (MTFC): results from an independent replication. *Journal of Family Therapy*, 33(1), 20-41. Websites: http://www.tfcoregon.com/ http://www.cebc4cw.org/program/treatment-foster-care-oregon-adolescents/detailed http://www.blueprintsprograms.com/factsheet/treatment-foster-care-oregon

Program name	KIDS IN TRANSITION TO SCHOOL (KITS)
Originator/Organisation	Oregon Social Learning Center
Aims and conceptual base	Short term intervention to promote school readiness and promote school functioning.
Target population / eligibility	Preschool children in foster and kinship care and other children at high risk for school difficulties
Intervention level(s)	Families who function well Families who have some difficulties Families at risk of child maltreatment Families receiving statutory child protection services Children living in out-of-home care
Delivery mode	Children attend groups structured like a kindergarten class – two sessions per week for eight weeks before they start school and one session per week for eight weeks after school starts (total 24 sessions). Caregivers attend 12 workshops (weekly in the summer and every other week once school starts).
Core program components	Children's sessions focus on: • Literacy • Numeracy • Self-regulation • Social skills Parents' sessions focus on: • How to increase early literacy skills at home • Establishing school routines • How to become involved with schooling • How to encourage positive behaviours at home and school.
Associated outcomes	• Reduced aggressive and oppositional behaviours[1] • Improved early literacy[1] • Improved self-regulation[2] • Reduced ineffective parenting[1] • Increased parental involvement[1]
Evidence of effectiveness	[1] These outcomes have been demonstrated in one RCT (see http://www.cebc4cw.org/program/kids-in-transition-to-school-kits/detailed) [2] This outcome has been demonstrated in two RCTs (see http://www.cebc4cw.org/program/kids-in-transition-to-school-kits/detailed)

Effect size or measures of impact	Pears et al (2015) reported a decline in ineffective parenting for the treatment group relative to controls, this was a small effect.
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes. It has received a scientific rating of two from the California Evidence-Based Clearinghouse where it is listed as supported by research evidence. Two of the three published RCTs (conducted with the program's current structure) involved the same sample of children in foster care (findings included the first three listed outcomes). The authors noted that generalisability of these findings may be problematic due to the limited number of minorities and moderate sample size, in addition to reliance on self-report (Pears et al, 2012; Pears et al, 2013). The third RCT focused on children with developmental disabilities and behavioural difficulties, excluding children in foster care (findings included the last three listed outcomes). The authors noted again that there were challenges with generalisability, reliance on self-report and generally low rates of parent participation (Pears et al, 2015).
Training and accreditation requirements	Training involves 35 to 40 hours of workshops. Different sessions depending on role of staff (playgroup supervisor, playgroup lead teacher, playgroup assistant teachers, parent group supervisor, parent group lead facilitator, parent-group co-facilitator).
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by multiple RCTs with demonstrated effects on relevant parent and child outcomes. The program is also likely to be appealing to clients as it focuses on the challenging time of school transition.
Use in Australia	No.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	As an evidence-based system for teaching and changing behaviour, there is likely scope for necessary adaptation to local requirements.
Anticipated challenges to implementation in Victorian context	None.

Indicative scale of implementation costs	Not located.
Name of organisation holding Australian licence (if applicable)	N/A
References	Pears, K. C., Kim, H. K., & Fisher, P. A. (2012). Effects of a school readiness intervention for children in foster care on oppositional and aggressive behaviors in kindergarten. *Children in Youth Services Review*, 34, 2361-2366. Pears, C. K., Fisher, A. P., Kim, H. K., Bruce, J., Healey, V. C., & Yoerger, K. (2013). Immediate effects of a school readiness intervention for children in foster care. *Early Education and Development* 24, 771-791. Pears, K. C., Kim, H. K., Healey, C. V., Yoerger, K., & Fisher, P. (2015). Improving child self-regulation and parenting in families of pre-kindergarten children with developmental disabilities and behavioral difficulties. *Prevention Science* 16, 222-232. Websites: http://www.oslc.org/projects/kids-transition-school-kits/ http://www.cebc4cw.org/program/treatment-foster-care-oregon-adolescents/detailed

Program name	**KEEP SAFE** (formerly Middle School Success)
Originator/Organisation	Oregon Social Learning Centre
Aims and conceptual base	MSS was developed to support girls in foster care in the transition to middle school. In the short term it aims to promote healthy adjustment, increase prosocial behaviour, reduce internalising and externalising symptoms and increase stability of foster care placements. Longer term, MSS aims to reduce substance abuse and delinquency.
Target population / eligibility	Adolescent girls in foster care who are transitioning to middle school (ages 13-17), and their foster parents.
Intervention level(s)	Children living in out-of-home care
Delivery mode	Two sets of six parallel group sessions, one for girls and one for foster parents, with seven participants in each group. Groups meet twice per week for three weeks in the summer. Girls receive one-on-one sessions of ongoing training and support once per week for two hours during the school year. Parents receive follow up group sessions also once per week for two hours during the school year.
Core program components	Group sessions are manualised. Girls' sessions include an introduction, role plays and an opportunity to practice new skills through games or activities. Foster parents receive training in a behavioural reinforcement system to encourage adaptive behaviour and sessions focus on stability in the foster home, preparing to start middle school and preventing early adjustment problems. Foster parents receive home practice tasks to consolidate new skills each week.
Associated outcomes	• Reduced internalising problems[1] • Reduced externalising problems[1] • Reduced substance use[2] • Increased prosocial behaviour[2] • Reduced foster placement changes[2] • Improvements in offending and violent behaviour[3] • Reduced risky sexual behaviour[3] • Reduced self-harm[3] • School activities[3]
Evidence of effectiveness	[1]These outcomes have been demonstrated in two RCTs (see http://www.childtrends.org/?programs=middle-school-success-mss) [2] These outcomes have been demonstrated in one RCT (see http://www.childtrends.org/?programs=middle-school-success-

	mss) [3] Differences on these outcomes were reported from baseline to 12 month follow up in US and UK intervention samples (see Rhoades et al., 2013).
Effect size or measures of impact	Kim and Leve (2011) found that the intervention was negatively correlated with foster placement changes at six and 12 months post-intervention. This was a small to medium effect. Blueprints reports effect sizes were generally moderate at the two-year follow-up, with Cohen's d ranging from .45 to .50 for significant outcomes Effect sizes emerging in the US and UK trials were generally similar, with the exception of the effect on substance abuse (which was not observed in the UK sample).
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child outcomes with maintenance of some effects demonstrated up to 36 months post intervention. It is listed as a program that 'works' by Child Trends. Kim and Leve (2011) note that limitations included a lack of ethnic diversity and the relatively small sample of 100 girls. These limitations were also noted by Smith, Leve and Chamberlain (2011) indicated that replication in other regions and cities is needed before widespread implementation of the intervention would be advisable.
Training and accreditation requirements	According to the Blueprints entry for Keep Safe, facilitators of the parent groups are experienced foster parents with Bachelor-level degrees, or child welfare case workers. Youth group facilitators and assistants are supervised by a masters or doctoral level clinician. Training involves an experiential five-day training workshop where the curriculum is reviewed via delivery to colleagues along with discussion about group processes, logistics, and supervision. Facilitators apply for certification, and when fidelity benchmarks are achieved, the facilitator can continue delivering the program without weekly consultation sessions (to address fidelity). Certified facilitators undergo quarterly fidelity checks and are eligible to undergo further training as a trained trainer.
Acceptability	Given the caution of researchers in relation to the need for further validation, this intervention may not be acceptable to practitioners in Victoria at this stage. A compounding factor is that it is a relatively long term intervention with follow up support provided throughout the school year. However, it appears to be a promising practice so further consideration may be given to

	smaller-scale use of this program with appropriate monitoring and research support to investigate the potential for wider application if positive outcomes are replicated. The program may be acceptable to clients. According to Blueprints, researchers reported that parents attended an average of 5.62 of 6 key Keep Safe sessions (and 20 of 40 follow-up sessions), that youth attendance was similar, and that participants were from diverse racial/ethnic groups.
Use in Australia	No
Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	Sessions are manualised, but likely to be adaptable to local requirements if required. The program has been implemented in the US, UK, and Sweden, and may therefore be adaptable for use in Australia.
Anticipated challenges to implementation in Victorian context	None.
Indicative scale of implementation costs	According to Blueprints, the start-up cost for initial training and technical assistance (Keep Safe) is : • $40,000 for a five-day, on-site training for a facilitator and co-facilitator; execution of a contract along with site readiness activities; weekly recording and upload of KEEP SAFE group sessions via a HIPAA-compliant system; weekly consultations with a KEEP SAFE consultant; and fidelity review for certification after the facilitator has competed three KEEP SAFE groups. Up to four additional teams (facilitator and co-facilitator) can be added to the training for an additional $24,000 per team. These costs do not include travel and related expenses (airfare, hotel, per diem) for the trainers." • Quarterly fidelity monitoring and evaluation costs $3000 (US)
Name of organisation holding Australian licence (if applicable)	N/A
References	Kim, H.K., Leve, L.D. (2011). Substance use and delinquency among middle school girls in foster care: A three year follow-up of a randomized controlled trial. *Journal of Consulting Clinical*

Psychology, 79(6), 740-750.

Kim, H. K., Pears, K. C., Leve, L. D., Chamberlain, P. C., & Smith, D. K. (2013). Intervention effects on health-risking sexual behavior among foster care girls: The role of placement disruption and substance use. Journal of Child and Adolescent Substance Abuse, 22(5), 370-387.

Rhoades, K., Chamberlain, P., Roberts, R., & Leve, L. (2013). MTFC for high risk adolescent girls: A comparison of outcomes in England and the United States. Journal of Child and Adolescent Substance Abuse, 22(5), 435-449.

Smith, D.K., Leve, L.D., Chamberlain, P. (2011). Preventing internalizing and externalizing problems in girls in foster care as they enter middle school: immediate impact of an intervention. *Prevention Science*, 12(3), 269-277.

Websites:

http://www.oslc.org/projects/middle-school-success-project/

http://www.childtrends.org/?programs=middle-school-success-mss#sthash.qAK9i74n.dpuf

http://www.blueprintsprograms.com/evaluation-abstract/keep-safe

Promising

Program name	CHILD PARENT PSYCHOTHERAPY
Originator/Organisation	Child Trauma Research Program, University of California San Francisco
Aims and conceptual base	To support and strengthen the caregiver-child relationships as a mechanism to restore and protect child mental health and promote development.
Target population / eligibility	Children (birth to five years) who have experienced trauma, and their caregivers.
Intervention level(s)	Families at risk of child maltreatment Families receiving statutory child protection services Children living in out-of-home care
Delivery mode	Weekly 60 to 90 minute sessions for 12 months in child-parent dyads. Treatment settings include the home (birth, adoptive, or kinship/foster), community agency, outpatient clinic, or school.
Core program components	Focus of the intervention is on the parent-child relationship. Sessions cover topics including safety, affect regulation, reciprocity in relationships, traumatic events and the continuity of daily living. Content of sessions depends on the child's age and developmental status.
Associated outcomes	• improved maternal empathy[1] • improved parent-child relationship[1] • improved attachment[2] • improved child cognitive development[1] • fewer child behaviour problems[1] • fewer child post-traumatic stress symptoms[1] • fewer maternal mental health symptoms[1]
Evidence of effectiveness	[1] These outcomes have been demonstrated in at least one RCT (see Lawler, Shaver & Goodman, 2011) [2] This outcome has been demonstrated in at least two RCTs (see Lawler, Shaver & Goodman, 2011)
Effect size or measures of impact	Lieberman, Van Horn & Gosh Ippen (2005, n=75) reported a medium-size effect for reductions in child traumatic stress symptoms and behaviour problems. At intake, there was no statistically significant group difference in the number of children meeting criteria for a Traumatic Stress Disorder (TSD) diagnosis (50% vs 39% for the CPP and control group respectively). At post-test, a significant group difference did emerge, with only 6% of CPP children compared with 36% of the comparison group

	meeting criteria for TSD.
Analysis of evidence of effectiveness	Efficacy of CPP has been demonstrated in a number of RCTs over the past two decades. It is listed as a promising practice on the National Traumatic Stress Network website and has received a scientific rating of two (out of five) from the California Evidence-Based Clearinghouse, where it is listed as supported by research evidence. Lawler, Shaver & Goodman (2011) conclude that CPP is an effective approach to working with traumatised families to solve attachment problems undermining security and promoting better child-parent relationships.
Training and accreditation requirements	CPP courses involve 18 months of training with three face-to-face learning sessions and twice monthly telephone or video consultation.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by multiple RCTs with demonstrated effects on relevant child outcomes, though training is intensive over a long period of time. The program is also likely to be acceptable to clients.
Use in Australia	Training offered in Australia for the first time in 2016 by the Australian Association for Infant Mental Health
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	Content of sessions is flexible so any necessary adaptation should be possible.
Anticipated challenges to implementation in Victorian context	Intensive training over an 18-month period could be challenging to implement.
Indicative scale of implementation costs	Cost information available from the SAMHSA's National Registry of Evidence-based Programs and Practices: • Program manual 'Repairing the Effects of Stress and Trauma on Early Attachment' $35.79 (US) hardcover, $28 (US) paperback, or $21.95 (US) Kindle • Program manual for 'Don't Hit My Mommy' (for young witnesses of family violence) $24.95 (US) • $1,500-$3,000 per day for training (depending on trainer experience) for up to 30 participants, plus travel expenses • $150-$350 per hour for additional phone, email or in-person consultation (depending on trainer experience), plus travel expenses

Name of organisation holding Australian licence (if applicable)	N/A
References	Lawler, M. J., Shaver, P. R., & Goodman, G. S. (2011). Toward relationship based child welfare services. *Children and Youth Services Review*, 33(3), 473-480. Lieberman, A.F, Van Horn, P. and Gosh Ippen, C. (2005). Toward evidence-based treatment: Child-parent psychotherapy with pre-schoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry,* 44(12) 1241-1248. Websites: http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed http://legacy.nreppadmin.net/ViewIntervention.aspx?id=194 http://nctsn.org/resources/topics/treatments-that-work/promising-practices

Program name	**FOSTERING HEALTHY FUTURES** For program details see the Placement and Reunification Section.

Program name	**MULTISYSTEMIC THERAPY FOR CHILD ABUSE AND NEGLECT (MST-CAN)**
Originator/Organisation	Global Family Solutions LLC
Aims and conceptual base	MST-CAN was designed to treat children and their families who come to the attention of child protective services due to physical abuse and/or neglect. The program aims to: • keep families together • assure that children are safe • prevent abuse and neglect • reduce mental health difficulties • increase natural social supports.
Target population / eligibility	Children (six to 17 years) and their families who have experienced physical abuse and/or neglect.
Intervention level(s)	Families at risk of child maltreatment Families receiving statutory child protection services
Delivery mode	MST-CAN is delivered to families in the home for a minimum of three sessions per week over six to nine months. All members of the family are involved in the treatment. Session length and frequency depend on the needs of families, and may range from 50 minutes to two hours. Multiple sessions may be conducted in one day and treatment is available 24 hours per day, seven days per week.
Core program components	According to the California Evidence-Based Clearinghouse MST-CAN staff teams include three therapists, a crisis caseworker, a part-time psychiatrist and a full-time supervisor. MST-CAN strategies include safety planning, cognitive behavioural therapy for managing anger and addressing the impact of trauma, reinforcement-based therapy for adult substance abuse, family therapy focused on communication and problem solving, and support for parents to take responsibility for whatever events brought the family to the attention of child protective services. Each therapist carries a maximum caseload of four families. There is regular weekly on-site group supervision, weekly telephone contact with a MST-CAN expert and measurement of model adherence through monthly phone interviews with parents or caregivers.

Associated outcomes	• Reduced youth mental health symptoms • Reduced parent psychiatric distress • Reduced parenting behaviours associated with maltreatment • Reduced youth out-of-home placements and changes in placements • Improved natural social support for parents
Evidence of effectiveness	The above outcomes have been demonstrated in one RCT. Related research, including a literature review is available from http://www.mstcan.com/research/
Effect size or measures of impact	Swenson et al (2010) found that the intervention was more effective compared to treatment as usual in reducing neglect as reported by parents (small effect) and youth (large effect), minor assault (youth report, small effect) and severe assault (parent and youth report, both medium effects) through to 16 months post-baseline. Swenson et al (2010) also reported that youth who received the intervention were less likely to experience an out-of-home placement over 16 months compared to youth in the treatment as usual condition (small to medium effect). They also experienced fewer placement changes (large effect).
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on multiple child and parent outcomes. It has received a scientific rating of two (out of five) from the California Evidence-Based Clearinghouse, where it is listed as supported by research evidence. Limitations of the RCT conducted on MST-CAN include a relatively small sample of 86 families in one geographic area (Charleston County) and reliance on self-report for some measures (Swenson et al, 2010). The study recruitment rate was 98% and research retention was 97% through to the end of 16 months.
Training and accreditation requirements	Five days of MST orientation training, four additional days of MST-CAN specific training and four days of training in adult and child trauma. Quarterly on-site booster training is conducted by a MST-CAN expert. Weekly telephone conversations with a MST-CAN expert are also provided.
Acceptability	MST-CAN is a resource-intensive intervention where therapists are available to families 24 hours per day, seven days per week. This intervention would likely only be acceptable to professionals if caseloads were low (as recommended) and a high level of support was provided to workers.
Use in Australia	No

Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	The MST-CAN website indicates MST-CAN is currently available in the Netherlands, Switzerland, the UK and the US. Given this broad geographic spread of existing programs, it is likely the program can be adapted for any local Victorian requirements.
Anticipated challenges to implementation in Victorian context	None, other than intensive resourcing requirements indicated above.
Indicative scale of implementation costs	Not located.
Name of organisation holding Australian licence (if applicable)	N/A
References	Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. (2010). Multisystemic Therapy for Child Abuse and Neglect: A randomized effectiveness trial. *Journal of Family Psychology*, 24, 497-507. Websites: http://www.mstcan.com/ http://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/detailed

Program name	**COGNITIVE BEHAVIORAL THERAPY FOR SEXUALLY ABUSED PRESCHOOLERS (CBT-SAP)** (also known as Trauma-focused CBT)
Originator/Organisation	Dr Judith Cohen and Dr Anthony Mannarino University of Pittsburgh
Aims and conceptual base	CBT-SAP targets child development, child behaviour, parent-child relationships and family relationships.
Target population / eligibility	3-6 year old children with a history of maltreatment
Intervention level(s)	Families receiving statutory child protection services
Delivery mode	12 sessions delivered weekly by professionals to individual parent-child dyads in a clinical setting. Parent sessions run for one hour. Child sessions run for between 30 minutes to one hour, depending on the child's ability to maintain attention (see Cohen & Mannarino, 1993).
Core program components	CBT-SAP involves delivery of cognitive behavioural therapy to parents and children in the form of cognitive reframing, thought stopping, positive imagery and contingency reinforcement. Parenting management training is also provided, as well as problem solving, psychoeducation and supportive interventions (Macvean et al 2013) Content for parents includes: • Ambivalence about belief in the sexual abuse • Ambivalence towards the perpetrator • Attributions regarding the abuse • Feelings that the child is damaged • Management of child fear and anxiety • Provision of appropriate emotional support to the child • Management of appropriate behaviours • Dealing with the parents issues in relation to their own abuse Content for the child includes: • Attributions regarding the abuse • Ambivalent feeling towards the perpetrators • Child safety and assertiveness training • Appropriate versus inappropriate touching • Inappropriate behaviour • Issues of fear and anxiety
Associated outcomes	• Fewer internalising or externalising behaviour problems

	in children [1] • Less sexualising behaviours of children [2] • Less problematic child behaviour [1, 2]
Evidence of effectiveness	[1]These outcomes have been demonstrated in at least one RCT (see Cohen & Mannarino, 1996; Macvean et al 2013) [2]These outcomes have been demonstrated in at least one RCT with 12 month follow up (see Cohen & Mannarino, 1998; Macvean et al 2013)
Effect size or measures of impact	Through multiple regression analyses, Cohen & Mannarino (1998) found that the treatment group accounted for 24 to 28% of total variance in weekly parent report of child behaviour (24% for type and 28% for total). They also found that treatment group accounted for 13% of variance on parent reported child sexual behaviour. Cohen & Mannarino (1996) did not report effect sizes for their analyses.
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on child behaviour and parent-child and family relationships with maintenance of effects demonstrated up to 12 months post intervention. Limitations of studies include a lack of multiple RCTs to demonstrate replication of effects. Sample size was relatively small (*N* = 67).
Training and accreditation requirements	Sessions delivered by professional clinicians
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by at least one RCT with 12 month follow up. The program is also likely to be acceptable to clients as the duration is relatively short (12 weeks)
Use in Australia	No
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation	Clinical settings allow for intimate content delivery and flexibility

to local requirements	tailored to individual family and child needs.
Anticipated challenges to implementation in Victorian context	N/A
Indicative scale of implementation costs	No cost information was located.
Name of organisation holding Australian licence (if applicable)	N/A
References	Cohen, J.A., & Mannarino, A.P. (1993). A treatment model for sexually abused preschoolers. *Journal of Interpersonal Violence,* 8(1), 115-131. Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(1), 42-50. doi: http://dx.doi.org/10.1097/00004583-199601000-00011 Cohen, J. A., & Mannarino, A. P. (1998). Factors that mediate treatment outcome of sexually abused preschool children: Six- and 12-month follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*(1), 44-51. doi: 10.1097/00004583-199801000-00016 Macvean, M., Mildon, R., Shlonsky, A., Devine, B., Falkiner, J., Trajanovska, M., D'Esposito, F. (2013). Evidence review: An analysis of the evidence for parenting interventions for parents of vulnerable children aged up to six years (commissioned by the Families Commission of New Zealand), Parenting Research Centre, Melbourne.

Program name	BIG BROTHERS, BIG SISTERS (BBBS)
Originator/Organisation	Kristin Romens Big Brothers Big Sisters National Office 2202 N. Westshore Blvd, Suite 455, Tampa, FL 33607 Main Phone: (813) 720-8778 Fax: (813) 749-9446 http://www.bbbsa.org
Aims and conceptual base	BBBS's mission is to provide supportive relationships for young people to assist them in realising their potential. As a community mentoring program, BBBS promotes positive development by matching a volunteer adult mentor to an at-risk child or adolescent. The programs aims are to delay or reduce antisocial behaviours; improve academic success, attitudes and behaviours, peer and family relationships; strengthen self-concept; and provide social and cultural enrichment.
Target population / eligibility	BBBS is implemented with disadvantaged youth who have risk factors such as a history of abuse or neglect, or from single-parent households. Youth are predominantly aged 10-14 years (minimum age is 6 and maximum age is 18). It has been shown to be effective for both males and females.
Intervention level(s)	Families receiving statutory child protection services. Children living in out-of-home care.
Delivery mode	BBBS traditional model operates within community settings and can be delivered to young people living with their parents or in foster and kinship care. BBBS school-based model runs entirely out of the school system and encourages participation from a wider range of volunteers and youth. It allows weekly breaks from regular programming for the child to take part in one-to-one activities with the mentor, within the school environment. Volunteer mentors commit to spending approximately three to five hours per week with the child for at least one year.
Core program components	The BBBS program is a mentor service which focuses on providing participants with a positive, caring, and supportive role model. The program does not include a behaviour-specific interventions or target specific behaviours (such as academic improvement, drug use, or violence). Through the use of mentors the program has been shown to impact on a variety of behavioural outcomes and has been used successfully with young people living at home and in foster or kinship care. After referral to the program, an initial interview is held with BBBS staff, the parent and child to help set goals for the child.

Associated outcomes	• Improved prosocial behaviours, skills and self-esteem[1, 2, 3] • Improved academic outcomes[1, 2] • Delayed initiation of substance use[1] • Improved quality of relationship with parents and peers[1] • Reductions in violent behaviour and conduct problems[2]
Evidence of effectiveness	[1]These outcomes have been demonstrated in at least one RCT (see http://www.promisingpractices.net) [2]These outcomes have been demonstrated in at least one RCT with 12 and 18 month follow-ups (see http://www.promisingpractices.net) [3]These outcomes have been demonstrated in at least one RCT with 6 month follow-up (see Rhodes, Haight, & Briggs, 1999)
Effect size or measures of impact	BBBS youths were 46% less likely to initiate illegal drug use, and 27% (marginally significant) less likely to initiate alcohol use.[1] BBBS youths were 32% less likely to hit someone.[1] BBBS youths attained a marginally significant rise in grade point averages (GPAs), with average GPAs of 2.71 versus 2.63 for control group.[1] Girls participating in BBBS attained significantly higher GPAs than control girls, with an average GPA of 2.84 versus 2.67.[1] On average participating youths were 52% less likely to skip a day of school. Girls who participated in BBBS skipped 84% fewer days than control group girls, with minority girls skipping 78% fewer days and white girls skipping 90% fewer days.[1] At 12 month follow up, teachers reported a lower percentage of serious school offenses (fighting, principal's office visits, and suspensions in the past four weeks) committed by BBBS youths (14% versus 21% control), and a lower percentage of unexcused absences in the past four weeks (12% versus 18% control).[2] At 12 month follow up, fewer youths reported having started to skip school (11% versus 17% control).[2]
Analysis of evidence of effectiveness	This program is supported by multiple RCTs demonstrating effectiveness on behaviour, school performance, substance use and violence, with maintenance of effects demonstrated up to 12 and 18 months post intervention. The BBBS program is rated as a 'promising' program by Blueprints, and is rated 'Proven' by Promising Practices. A limitation of many studies conducted on BBBS is that they are typically very small and lack methodological rigor. This is not the case in the 1995 study by Tierney, Grossman, and Resch, however in this study set the significance level was p<=.10, rather the standard p<.05.
Training and accreditation	Individual programs adhere to required Big Brothers Big Sisters national guidelines and standards.

requirements	The program requires extremely rigorous screening of its volunteers and youth. Mentors undergo initial and continuing training to aid them in building a successful and supportive relationship, and youth-mentor relationships are closely monitored by a Match Support Specialist during the first year of development. Whilse the BBBS program does not have a prescribed curriculum, participation in the program requires a high level of personal commitment and commitment of time and energy.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by multiple RCTs with 12 and 18 month follow-ups. The program is also likely to be acceptable to clients as it offers structured guidelines which allow the flexibility to be adapted to the individual's needs. Program content is appropriate to a wide variety of cultural backgrounds, SES circumstances including parental incarceration or military deployment, and may adapt well to indigenous groups. Retention in the Tierney, Grossman, & Resch (1995) study was 84.3% (*N* = 959). Further, with the introduction of the school based program, BBBS has the opportunity to reach a wider number of young people in need.
Use in Australia	Big Brothers Big Sisters Australia Limited. (ABN 75 071 682 294) National Office: The Jewel Business Centre, Suite 604, 566 St Kilda Road, Melbourne VIC 3004. E-mail: support@bbbsau.org Phone: (03) 9526 8409
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	BBBS Australia has been running for 30 years.
Anticipated challenges to implementation in Victorian context	N/A
Indicative scale of implementation costs	Program cost information available from Promising Practices Network: Big Brothers Big Sisters is traditionally funded through local fundraising efforts from the business, faith, and educational communities, as well as through private and public foundation support. The national average cost of making and supporting a match between a youth and an adult volunteer is approximately $1,000. Program cost varies depending on the agency and geographic location of the program.

	Program cost information available from Blueprints: BBBS of America advises that a new program start-up would need a minimum of $250,000 for costs to ensure sustainability and quality matches. This would purchase training for staff, set up an office and provide money for cash flow to cover revenue fluctuations.
Name of organisation holding Australian licence (if applicable)	Big Brothers Big Sisters Australia Limited. (ABN 75 071 682 294) National Office: The Jewel Business Centre, Suite 604, 566 St Kilda Road, Melbourne VIC 3004. E-mail: support@bbbsau.org Phone: (03) 9526 8409
References	Herrera, C., et al., (2007). *Making a difference in schools: The Big Brothers Big Sisters school-based mentoring*. Philadelphia: Public/Private Ventures. Rhodes, J.E., Haight, W.L., and Briggs, E.C. (1999). The influence of mentoring on the peer relationships of foster youth in relative and nonrelative care. *Journal of Research on Adolescence, 9*(2). 185-201. Shlonsky, A., Kertesz, M., Macvean, M., Petrovic, Z., Devine, B., Falkiner, J., D'Esposito, F., and Mildon, R. (2013). *Evidence review: Analysis of the evidence for out-of-home care.* East Melbourne, Victoria: Parenting Research Centre. Tierney, J.P., Grossman, J.B., and Resch, N.L. (1995). *Making a difference: An impact study of Big Brothers Big Sisters.* Philadelphia: Public/Private Ventures. http://www.bbbs.org/site/c.9iILI3NGKhK6F/b.5962335/k.BE16/Home.htm

Program name	TOGETHER FACING THE CHALLENGE
Originator/Organisation	Maureen Murray, LCSW Duke University Medical Centre Department: Services Effectiveness Research Program Email: murra024@mc.duke.edu Phone: (919) 687-4686 x302 Fax: (919) 687-4737
Aims and conceptual base	Together Facing the Challenge aims to improve practice in treatment foster care through training and consultation. Built from studies of "usual care" the program identified which components best led to improved outcomes for youth and then incorporated elements from existing evidence-based treatments to fill identified gaps. The program is designed as a train-the-trainer approach, so that treatment foster care administration and supervisory personnel can learn the training, and model and train treatment foster parents. The program goals for both therapeutic foster parents and supervisors are: • To build therapeutic relationships. • Perform and teach cooperation skills. • Implement effective parenting techniques (communicate effectively, set expectations, reinforce positive behaviour, avoid power struggles, etc.). • Teach independence skills to prepare youth for the future. • Create a positive home environment through family fun time, taking care of self, family meetings, etc. • And to generally improve outcomes for youth served in therapeutic foster care settings.
Target population / eligibility	TFC is a program designed for treatment foster parents and agency staff, for parents or caregivers of children with emotional and behavioural problems aged 3 to 17 years.
Intervention level(s)	Children living in out-of-home care
Delivery mode	This program provides training on practical parenting and supervisory skills and techniques. Training for treatment foster parents runs over 6 weeks, one x 2 hour session per week, with follow-up booster offered at 6 and 12 months post-training.
Core program components	The program provides comprehensive training for agency staff and treatment foster care parents in classes of 15 to 20 participants.

	Topics covered are: • Building and maintaining a therapeutic relationship by exhibiting genuine verbal and non-verbal behaviours • Teaching cooperation • Teaching the ability to implement effective discipline techniques within the context of a supportive and environment. • How to address difficult thoughts and feelings, and help the child to understand how these thoughts and feelings can impact behaviours. • Interrupting the conflict cycle and de-escalating the situation. • Problem solving techniques to address specific problems (define it clearly, generate multiple solutions, and select best solution based on outcomes). • Teaching relevant life skills by transforming daily living activities into learning opportunities, assisting youth to develop independent living skills • Taking care of yourself, recognising the impact of stress, the 'warning signs' and specific strategies used to manage stress levels.
Associated outcomes	• Reduced conduct problems and problem behaviours • Improved peer relationships and prosocial behaviours • Decreased long term problem behaviours • Increased interpersonal strength, family involvement and school functioning
Evidence of effectiveness	These outcomes have been demonstrated in at least one RCT with 6 and 12 month follow-ups (see Farmer et al, 2010).
Effect size or measures of impact	The authors suggest that a youth in the intervention group who had a mean level of problems at baseline (scoring 5.5) would have, on average, a score of 4.2 at six months and 3.8 at 12 months. They suggested changes on the Strengths and Difficulties Questionnaire (SDQ) Total Difficulties scale would similarly go from 17.5 at baseline, to 14.3 at six months, and 16.0 at 12 months. Overall, effects were larger for behaviours and symptoms (measured using a Parent Daily Report and the SDQ) than strengths (as measured on the Behavioural and Emotional Rating Scale).
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on child and family wellbeing with maintenance of effects demonstrated up to six months post intervention. The program was rated 'Emerging' in a 2013 review by the Parenting Research Centre, and it has received a scientific rating of two (out of five) from the California Evidence-Based Clearinghouse, where it is categorised as supported by research evidence.
Training and	

accreditation requirements	Agency staff training is run as a two or three day intensive seminar, with groups of 15 to 30 participants. Training is led by the program director, with assistance from existing treatment foster care agency supervisors. Initial training is usually conducted at a location set up by the agency making the request for the training. A typical schedule might be 9am to 4pm with an hour for lunch and two 15 minute breaks. Specific information pertaining to scheduling and materials needed are arranged on a site-by-site basis with a contractual agreement specifying the details of the plan. Follow-up phone consultations occur after completion of training and typically occur once a month for six months to one year. Training for treatment parents is conducted over a six-week period, with weekly 150 minute sessions.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by at least one RCT with six and 12 month follow-ups. The program is also likely to be acceptable to clients as it enhances existing processes. It does not require any additional staffing, just the introduction of training to existing staff.
Use in Australia	Unknown
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	Program delivery may be adapted to Victorian requirements as it is typically conducted in community agency/department of social service settings.
Anticipated challenges to implementation in Victorian context	N/A
Indicative scale of implementation costs	No information on costing or cost effectiveness was located.
Name of organisation holding Australian licence (if applicable)	N/A
References	Farmer, E. M. Z., Burns, B. J., Wagner, H. R., Murray, M., and Southerland, D. G. (2010). Enhancing "usual practice" Treatment

	Foster Care: Findings from a randomized trial on improving youth outcomes. *Psychiatric Services, 6*, 555-561. Shlonsky, A., Kertesz, M., Macvean, M., Petrovic, Z., Devine, B., Falkiner, J., D'Esposito, F., and Mildon, R. (2013). *Evidence review: Analysis of the evidence for out-of-home care.* East Melbourne, Victoria: Parenting Research Centre. http://www.cebc4cw.org/program/together-facing-the-challenge/detailed

Program name	**FOSTERING INDIVIDUALISED ASSISTANCE PROGRAM (FIAP)** For details of this program see the Placement and Reunification Section.

Program name	**LIFE STORY INTERVENTION**
Originator/Organisation	Wendy Haight
Aims and conceptual base	Developed by a trans-disciplinary team including child clinical psychologist, counsellor, psychiatrist, developmental psychologist, child welfare professional and social worker, this program is a narrative- and relationship-based intervention aiming to educate and correct misinformation about substance abuse, encourage a sense of mastery over traumatic events, and improve the mental health of foster children.
Target population / eligibility	Rural foster children aged seven to 17 years from families with methamphetamine problems
Intervention level(s)	Children living in out-of-home care
Delivery mode	This intervention occurs over a seven month period, involving weekly individual one hour sessions delivered in and around the child's home. The program is delivered by community-based, masters degree level professions experienced in working with children (e.g. teachers, counsellors, child welfare workers).
Core program components	The program is described as 'culturally-shaped' and involves local story-telling traditions in a narrative-and relationship-based intervention. The first two months of intervention focus on building a relationship with the child and may involve the clinician engaging in activities of the child's choosing (e.g. walks, playing with pets). In the following four months, clinicians encourage the construction of personal narratives. This framework emphasizes creating stories as a way to help children make sense of their lives, gain feelings of control and continuity, and alter problematic beliefs around substance misuse and trauma. The final month of the program focuses on termination issues; it includes discussion about the end of the program, identification of a trustworthy and supportive adult in the child's existing social network, and review of progress. Features designed to enhance cultural appropriateness of the program include the use of local professionals, provision of the intervention in the child's home and local surrounds, and the narrative approach.
Associated outcomes	• Externalising behaviour problems
Evidence of effectiveness	This program is supported by a single mixed-method study including both a qualitative and quantitative analysis. A significant time by group effect was observed, showing externalising scores decreased among children receiving the intervention and increased at seven month follow up for control children.

Effect size or measures of impact	The size of the effect on externalising scores was modest. Similar trends emerged for ratings of internalizing and total problems scores (on the Child Behaviour Check List), but these differences were not statistically significant.
Analysis of evidence of effectiveness	Although the study included random assignment to groups, it is limited by a small sample size (n=15) and relatively short timeframe (7 months) for follow up. Further research is needed to demonstrate its effectiveness.
Training and accreditation requirements	Weekly training and supportive supervision is provided to community clinicians in a small group setting. This training is provided by a PhD level clinical psychologist or psychiatrist experienced in working with traumatized children and drug-involved families
Acceptability	Given the single RCT, conducted in the USA, with a very small sample, and limited quantitative evidence of effectiveness, there is a clear need for further validation of the approach, and as such, this intervention may not be acceptable to practitioners in Victoria at this stage. Community clinicians in the study were generally positive about their experiences but also noted delivery in and around the home presented challenges to confidentiality and maintaining professional boundaries, and concern around termination of the program for children who had a history of multiple and traumatic disruptions in their relationships with adults. Haight et al (2010) see Life Story Intervention "as a bridge, bringing a needed intervention to children at a critical time in their lives prior to engagement in a longer-term mental health intervention." (p.1456) As narrative-based interventions are considered a culturally sensitive treatment modality the program may be acceptable to a variety of client groups within Australia. Qualitative evidence from children and families participating in the program suggests it was generally well-received.
Use in Australia	No
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	The program is flexibly adapted to the child's tolerance and likely to be adaptable to local requirements.
Anticipated challenges to implementation in Victorian context	Perceived acceptability of the program given the limited evidence base may present a challenge to implementation.
Indicative scale of	Not located.

implementation costs	
Name of organisation holding Australian licence (if applicable)	Not applicable
References	Haight, W., Black, J., & Sheridan, K. (2010). A mental health intervention for rural, foster children from methamphetamine-involved families: Experimental assessment with qualitative elaboration. Children and Youth Services Review, 32, 1446-1457.

Program name	**EMPOWERING PARENTS, EMPOWERING COMMUNITIES (EPEC)**
Originator/Organisation	Centre for Parent and Child Support, UK
Aims and conceptual base	To train local parents and support them in running peer-to-peer parenting groups in schools and children's centres
Target population / eligibility	Parents of children (aged birth to 11 years – material for teenagers is in development) from all backgrounds and with a wide range of difficulties.
Intervention level(s)	families who function well families who have some difficulties families at risk of child maltreatment families receiving statutory child protection services
Delivery mode	The program is delivered by trained family support workers and community workers. 'Being a Parent' groups are peer-led parenting programmes (two hours per week over eight weeks, total 16-hours). Local parents from diverse backgrounds are encouraged to train as facilitators of 'Being a Parent' groups. The facilitator training runs one day per week for 10 weeks (60 hours).
Core program components	The programme has two components. Parents in the community take part in facilitator training to deliver the 'Being a Parent' course. After completion of the training pairs of parent facilitators deliver 'Being a Parent' to groups of parents. Facilitator training covers: • Children's behaviour and parents' responses • Cultural and social influences on parenting styles • Supporting parents and parenting skills • Listening and communication • Group work theory and practice • Ethical and professional issues in parenting education Parent facilitators are supported through regular supervision. Additional workshops provide peer support and ongoing training via use of video of Being a Parent groups in action. Key topics covered in the 'Being a Parent' course include: • Self-esteem • Dealing with feelings • Understanding behaviour

	• Listening skills and • Setting limits Free crèches are provided alongside each parent group. Top-up workshops providing additional information are available for parents after completion of the course on topics such as: • Sibling rivalry. • Positive behaviour. • How to stop shouting and enjoy your children.
Associated outcomes	• Reduced child behaviour problems • Improved parenting confidence and competence • Improved parenting skills
Evidence of effectiveness	These outcomes have been demonstrated in at least one RCT (see Day et al, 2012).
Effect size or measures of impact	Intervention effect size of 0.38 (95% confidence interval 0.01 to 0.75, P=0.01). High rates of treatment retention (91.5%) and user satisfaction were found within the intervention group.
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on child behaviour problems and parenting confidence. Limitations of the study include the possibility of measurement bias due to openness of follow-up assessments, or shared method bias due to parental self-report measures.
Training and accreditation requirements	The facilitator training runs one day per week for 10 weeks (60 hours).
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by at least one RCT. The program is also likely to be acceptable to clients as it has been well researched and implemented within Australia by CCCH. The program is also likely to be cost effective as research has demonstrated improvements in child behaviour comparable in size to outcomes from trials involving professional therapists.
Use in Australia	Implemented in Tasmania and Victoria
Perceived 'fit' with the Victorian child & family service system	DHHS to advise

Potential for adaptation to local requirements	High, as the program is already being run in Tasmania.
Anticipated challenges to implementation in Victorian context	None, as the program is already being run in Tasmania.
Indicative scale of implementation costs	A licensing agreement may need to be obtained from EPEC. Cost for the license and training is variable.
Name of organisation holding Australian licence (if applicable)	Centre for Community Child Health
References	Day, C., Michelson, D., Thomson, S., Penney, C., and Draper, L. (2012). Evaluation of a peer led parenting intervention for disruptive behaviour problems in children: Community based randomised controlled trial. British Medical Journal, 344(1107). doi: 10.1136/bmj.e1107 (2) Winter, R. (2013*). Empowering Parents, Empowering Communities*. Prepared for Murdoch Children's Research Institute, Tasmania Early Years Foundation: Melbourne. Websites: http://www.earlyyears.org.au/projects/EPEC http://www.cpcs.org.uk/index.php?page=empowering-parents-empowering-communities

Programs supporting the transition to independent living

Best practice

Program name	TAKE CHARGE
Originator/Organisation	Not located.
Aims and conceptual base	TAKE CHARGE focuses on self-determination and provides academic support for the participants, as well as transition education and planning for those leaving care
Target population / eligibility	Adolescents with special education needs who are in foster care, leaving care or transitioning from care.
Intervention level(s)	Care leavers
Delivery mode	Weekly coaching sessions focussing on self-determination and transition planning are delivered to young people in the school setting over a 12 month period by trained and supervised coaches. Mentoring is also provided by adults with disabilities who have transitioned from foster care to independent living.
Core program components	TAKE CHARGE focuses on self-determination and provides academic support for the participants. Transition education and planning is provided for those leaving care. Participants are mentored by adults with disabilities who were previously in foster care. Support for parents is also provided.
Associated outcomes	• Statistically significant impact on self-determination at follow-up[1] • Better psychosocial outcomes and quality of life[1, 2] • Increase in the average number of independent living activities[1] • Positive effects on the use of transition services[1] • Improved goal setting abilities[2] • Improved educational planning, knowledge and engagement[2] • Decreased anxiety and depression, reduced withdrawn behaviours and somatic complaints[2]
Evidence of effectiveness	[1]These outcomes have been demonstrated in at least one RCT with 12 month follow up (see Powers et al 2012; Schlonsky et al 2013) [2]These outcomes have been demonstrated in one RCT with a 9

	month follow up (see Geenan et al 2012; Schlonsky et al 2013)
Effect size or measures of impact	Results for the intervention group revealed a large effect size (d = 1.09) on self-determination at follow-up, a moderate to large effect size (d = 0.77) on quality of life, and a moderate effect (d = 0.58) on the average number of independent living activities (Powers et al 2012). Results also showed a moderate effect (d = 0.65) on the use of transition services. (Powers et al 2012)
Analysis of evidence of effectiveness	This program is supported by one RCT on self-determination, goal setting abilities, educational planning, psychosocial outcomes and quality of life, with maintenance of effects demonstrated up to 12 months post intervention (see Green et al, 2012; Powers et al, 2012; Shlonsky et al, 2013) Although a statistically significant impact on self-determination was found at follow-up, it is worth noting that the groups differed at baseline on this variable, with the intervention group scoring lower, and it is not clear how the study adjusted for covariance (Shlonsky et al, 2013).
Training and accreditation requirements	Coaches complete formal training and observation, and attended weekly meetings to discuss their work and receive ongoing support. Coaching can be delivered by individuals with diverse backgrounds including school staff members, Master of Social Work students (Powers et al., 2012).
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an evidence based practice supported by multiple RCTs with nine to 12 month follow up and demonstrated effects on relevant child outcomes. The program is also likely to be acceptable to clients as it successfully manages youth transitioning out of care. Training and accreditation costs can be kept low due to the diverse backgrounds of coaches, and the program offers flexible one-on-one adaptability to individual participants with demonstrated effects among adolescent and young adult populations.
Use in Australia	No
Perceived 'fit' with the Victorian child & family	DHHS to advise

service system	
Potential for adaptation to local requirements	TAKE CHARGE is tailored to each individual participant and can be delivered via the school system. The program is likely adaptable to Victorian requirements.
Anticipated challenges to implementation in Victorian context	School compliance Coordinated efforts of child welfare agencies and school districts are essential for identifying youth in foster care and special education and for sharing resources in supporting them (Powers et al., 2012).
Indicative scale of implementation costs	No costing information was located.
Name of organisation holding Australian licence (if applicable)	N/A
References	Geenen, S., Powers, L., Powers, J., Cunningham, M., McMahon, L., Nelson, M., …Fullerton, A. (2012). Experimental Study of a Self-Determination Intervention for Youth in Foster Care. *Career Development and Transition for Exceptional Individuals*. doi: 10.1177/2165143412455431 Powers, L. E., Geenen, S., Powers, J., Pommier-Satya, S., Turner, A., Dalton, L. D., et al. (2012). My life: Effects of a longitudinal, randomized study of self-determination enhancement on the transition outcomes of youth in foster care and special education. *Children and Youth Services Review, 34*(11), 2179-2187. [1] Shlonsky, A., Kertesz, M., Macvean, M., Petrovic, Z., Devine, B., Falkiner, J., D'Esposito, F., Mildon, R. (2013). Evidence review: Analysis of the evidence for out-of-home care. Melbourne: Parenting Research Centre. Commissioned by the Community Services Directorate of the ACT Government.

Promising

Program name	MASSACHUSETTS ADOLESCENT OUTREACH PROGRAM FOR YOUTHS IN INTENSIVE FOSTER CARE (MA OUTREACH)
Originator/Organisation	Massachusetts' Department of Children and Families Services
Aims and conceptual base	This program is relationship-based and works one-on-one with young people to prepare them for adulthood. The aims are to help youths finish high school, continue their education, avoid high-risk behaviours, incarceration and homelessness, and to attain self-sufficiency and gainful employment. Other goals include achieving permanency through connections with a caring adult and identifying a support network.
Target population / eligibility	Youth in intensive foster care
Intervention level(s)	Children living in out-of-home care and care leavers
Delivery mode	Meetings typically occur weekly, although frequency is flexible to suit each participant's needs. Once a participant has reached their goals for the program, they move to a "tracking" status where outreach workers maintain monthly contact before discharging them from the program. On average, participants are involved with the program for 2 years, comprising 16 to 18 months of services followed by approximately six months of tracking.
Core program components	Youths are paired one-on-one with an outreach worker who works closely with them to achieve their goals. The program's services are individualised for each participant. Outreach workers directly assist participants with a variety of tasks and may refer participants to other organisations. Outreach workers' caseloads are limited to a maximum of 15 participants to enable them to focus on individual needs. Outreach is primarily focused on the following areas: Educational achievement, development of life skills, development of permanent connections and support systems, employment readiness, attaining employment, participation in post-secondary education, financial assistance, housing, physical and mental health, substance abuse treatment, relationship-building through mentoring, and, for youth who have

	not achieved legal permanency by age 18 years, assistance remaining in foster care after 18 years.
Associated outcomes	• More likely to have obtained important documents, such as a driver's licence or a birth certificate • More likely to enrol in post-secondary education and persist in college for more than one year • More likely to have stayed in care past the age of 18
Evidence of effectiveness	These outcomes have been demonstrated in a RCT with 12 month follow up (see Courtney, Zinn, Johnson, & Malm, 2011)
Effect size or measures of impact	The study found that significantly more Outreach youth reported being enrolled in college than youth in the regular foster care group (55.7 versus 37.4 percent). The study also found that a significantly greater percentage of Outreach youth persisted in college for at least one year compared with youth in the regular foster care group (48.9 versus 30.8 percent). None of the other outcomes of interest (grade completion, diploma/GED attainment, employment, earnings, and benefit receipt) were significantly different across groups.
Analysis of evidence of effectiveness	This program is supported by RCT-level evidence of effectiveness on further education enrolments, preparation for adulthood and independent living, with maintenance of effects demonstrated up to 12 months post intervention. It is recognised as an evidence based practice supported by CLEAR (Clearinghouse for Labor Evaluation and Research), USA. A small number (n = 10) of the control participants had some contact with outreach caseworkers, however it was unlikely they received services from the program. There is the potential that this crossover might have weakened the contrast between the study groups.
Training and accreditation requirements	Outreach workers must hold a bachelor's degree and be licensed social workers. They should be knowledgeable of local services and understand the resources available to adolescents.
Acceptability	This program is likely to be acceptable to professionals in the Victorian context as it is recognised as an effective practice supported by at least one RCT with 12 month follow up and demonstrated effects on relevant child outcomes. The program is also likely to be acceptable to clients as the

	individualised nature of the program allows for adaptability to individual participants, and has proven to be effective when used with adolescent and young adult populations transitioning out of care.
Use in Australia	No
Perceived 'fit' with the Victorian child & family service system	DHHS to advise
Potential for adaptation to local requirements	MA Outreach content is tailored to each participant based on a youth development model and the participant's own goals. The program is likely adaptable to Victorian requirements.
Anticipated challenges to implementation in Victorian context	None
Indicative scale of implementation costs	Not located.
Name of organisation holding Australian licence (if applicable)	Not applicable
References	Courtney, M., Zinn, A., Johnson, H., & Malm, K. (2011). Evaluation of the Massachusetts Adolescent Outreach Program for Youths in Intensive Foster Care: Final Report. *OPRE Report 2011-14*. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Shlonsky, A., Kertesz, M., Macvean, M., Petrovic, Z., Devine, B., Falkiner, J., D'Esposito, F., Mildon, R. (2013). Evidence review: Analysis of the evidence for out-of-home care. Melbourne: Parenting Research Centre. Commissioned by the Community Services Directorate of the ACT Government, http://clear.dol.gov/study/evaluation-massachusetts-adolescent-outreach-program-youths-intensive-foster-care-final-report

Programs designed for Indigenous and CALD Australians

Promising

Program name	**TAKE TWO (including trauma-focused educational package Yarning Up on Trauma)**
Originator/Organisation	Berry Street, in partnership with: • La Trobe University Faculty of Health Science • Mindful Centre for Training and Research in Developmental Health • Victorian Aboriginal Child Care Agency Funded by the Victorian Department of Health and Human Services
Aims and conceptual base	Take Two is a developmental therapeutic program for children and young people in the Victorian Child Protection system. The program works intensively with the distressed child or young person, and their carers, families and teachers, to help them understand their pain and learn to trust again. Take Two also works with services to provide consultation, training and guidance. 'Yarning Up on Trauma' is a Take Two education package which provides an approach to understanding trauma and attachment for Aboriginal children, Aboriginal communities and those working with the Aboriginal community.
Target population / eligibility	Children from birth to 18 years old who are clients of DHHS Child Protection Services, as well as their families and carers.
Intervention level(s)	Families receiving statutory child protection services Children living in out-of-home care
Delivery mode	Flexible delivery involving regular liaison, depending on content of individual family plan.
Core program components	When an infant, child or young person is referred to Take Two, thorough assessment is undertaken to get an understanding of what is happening for the child and everyone involved in their care. A therapeutic intervention plan is developed and goals are discussed with the child and their carer. The intervention can involve working directly with the child or young person by themselves, with the parent or carer or with others. Yarning Up on Trauma is an education package available as part of Take Two. Take Two employs clinically trained facilitators (one Aboriginal and one non-Aboriginal) to deliver Yarning Up on Trauma training. It is designed to provide workers with

	knowledge and understanding of the effects of trauma on their clients, themselves as Aboriginal people, Aboriginal communities and their work environments; and appropriate interventions based on trauma and attachment theories.
Associated outcomes	• Reduction in emotional and behavioural symptoms (as reported by children, parents, carers and teachers) • Reduction in trauma-related symptoms • Increase in strength of children's relationships within social networks
Evidence of effectiveness	The above outcomes have been demonstrated in a multi-year mixed-methods evaluation (Frederico, Jackson & Black, 2010). The Yarning Up on Trauma component has been evaluated using post-training surveys. These surveys found that participants found the content 'definitely' or 'mostly' helpful and trainers have received positive feedback about the ongoing application of their learning (Atkins, 2013).
Effect size or measures of impact	Frederico, Jackson & Black (2010) found that the percentage of parents reporting their children in the clinical range on the Strengths and Difficulties Questionnaire reduced from 90% at assessment, to 60% at time period. Note: there was substantial variation in when "time period two" occurred for each family. This varied from time of review (for example, six months after assessment) to closure (which could be two years after assessment). Frederico et al (2010) also found that the percentage of children who had at least one Trauma Symptom Checklist for Children score within the clinical range reduced from 49% at time one to 29% at time two (time between measures varied substantially, ranging from 15 to 150 weeks). Through analysis of social network maps, Frederico et al (2010) found that children listed significantly more friends at time two (average 23.9) compared to time one (average 15). Average listing of family members increased from 32.6 at the first time to 39.7 at the last time, though this was not statistically significant.
Analysis of evidence of effectiveness	This program is supported by evidence from a multi-year mixed methods evaluation that ran from June 2004 to June 2007. Although the evidence does not reach the RCT gold standard, results included in the final evaluation report by Frederico et al (2010) indicate Take Two has had some impact on outcomes for vulnerable children in Victoria. Limitations of the Frederico et al (2010) evaluation are detailed in Chapter Two of the final report and include challenges

	measuring constructs of interest, challenges describing and measuring Take Two's work and reliance on self-report measures.
Training and accreditation requirements	Training and accreditation requirements do not appear to be publically available.
Acceptability	Given that Take Two is a current part of the Victorian child and family service system, this program is likely to be acceptable to professionals and clients.
Use in Australia	Implemented state wide in Victoria
Perceived 'fit' with the Victorian child & family service system	As above, program already implemented in Victoria.
Potential for adaptation to local requirements	As above, program already implemented in Victoria.
Anticipated challenges to implementation in Victorian context	None. Program already implemented in Victoria.
Indicative scale of implementation costs	Information does not appear to be publically available.
Name of organisation holding Australian licence (if applicable)	Berry Street
References	Atkinson, J. (2013). Trauma-informed services and trauma-specific care for Indigenous Australian children. Resource sheet no. 21. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Frederico, M., Jackson, A., & Black, C. (2010). More than Words – The Language of Relationships: Take Two Third Evaluation Report. School of Social Work and Social Policy, La Trobe University, Bundoora, Australia. http://www.berrystreet.org.au/Therapeutic

Program name	**BENDING LIKE A RIVER: THE PARENTING BETWEEN CULTURES PROGRAM**
Originator/Organisation	Marymead Child and Family Centre, Australian Capital Territory
Aims and conceptual base	Bending Like A River aims to strengthen the ability of culturally and linguistically diverse (CALD) parents to parent confidently and capably in Australia. The program manual indicates the intervention was developed with strong attention to the balance between cultural identity and incorporating positive aspects of Australian society into parenting styles. Program aims listed in the manual are to: • raise awareness of what is important in families which work well • strengthen families' ability to transmit their cultural practices and beliefs • increase parents' ability to meet their own and their children's needs in a way which maintains family harmony • promote parents' understanding of how the school system operates • increase parental competency in non-physical discipline techniques and understanding of Australian child abuse laws; • share ways of gaining support from the informal and formal support systems.
Target population / eligibility	CALD families
Intervention level(s)	Families who function well Families who have some difficulties Families at risk of child maltreatment
Delivery mode	Single session or six week program options, noting the preference is to deliver a six week group program to help participants build supportive relationships and develop trust over time.
Core program components	Sessions focus on parenting issues particularly relevant to CALD communities, including: • intergenerational conflict arising from different acculturation rates • the benefits of bicultural parenting identity • knowledge of the school system • discipline strategies • knowledge of child abuse laws and support services. Sessions are solutions-focused and use a strengths based

	approach which involves: • identifying strengths and using these to solve problems; • focussing on identifying insights into solutions rather than problems; • emphasising that only small changes are necessary to make a difference; • encouraging a future focus and creating a picture of how things will be when the problem is solved; • stressing that people are experts on their own situations; • providing information and resources necessary for personal change (presenting some options for new ways of doing things).
Associated outcomes	• improved understanding of the impact of culture on parenting • improved parental knowledge of the school system • increased application of non-physical disciplinary measures • improved understanding of child abuse laws
Evidence of effectiveness	The above outcomes have been demonstrated in a qualitative evaluation (Kayrooz & Blunt, 2000).
Effect size or measures of impact	See Kayrooz and Blunt (2000)
Analysis of evidence of effectiveness	Evidence of effectiveness is emerging.
Training and accreditation requirements	Program manual is publically available, unclear if any additional training is required.
Acceptability	Quantitative information pertaining to acceptability was not located, however, the program has been designed with cultural sensitivity and competence in mind. In the 2012 report "Building Blocks: Best practice programs that improve the wellbeing of children and young people", the program was recommended as best practice.
Use in Australia	Bending Like a River has been implemented in the ACT and Western Australia.
Perceived 'fit' with the Victorian child & family service system	DHHS to advise.
Potential for adaptation to local requirements	Given the program has been implemented in an Australian state and territory, it is likely adaptable to any Victorian local requirements.
Anticipated challenges to implementation in	None.

Victorian context	
Indicative scale of implementation costs	Information not located.
Name of organisation holding Australian licence (if applicable)	Unclear if a licence is required.
References	Kayrooz, C. & Blunt, C. (2000) Bending like a river: The Parenting Between Cultures program. *Children Australia*, 25(3), 17-22. Marymead Child and Family Centre. (2000). Parenting Between Cultures: The Primary School Years. Program Manual. Available from www.marymead.org.au/

APPENDIX C: Search Strategy

Academic databases

Academic database searches were conducted in PsycInfo and Medline, limiting results to peer reviewed journal articles, published in the English language, between the years 2013 and 2016. Search results are presented in the table below.

Database	Search Strategy
PsycINFO	1. Keywords: (child neglect) OR (child abuse) OR (child maltreatment) OR (child protection) =30,632 2. Keywords: (program) OR (intervention) = 362,229 3. Combine Search 1 AND 2 = 5402 4. Limit year to 2013-2016= 874 5. Keywords: (review) =331,666 6. Combine searches 4 AND 5= 125 7. Limit to peer-reviewed journal articles and English language = 81 Screening titles and abstracts identified 16 reviews to consult further. Meta-analysis search: 1. Keywords: (child maltreatment OR child abuse OR child neglect OR child protection)=30632 2. Keywords: (program OR intervention)= 362229 3. Meta-analys* OR metaanalys*=22348 4. Combine Searches 1, 2, AND 3=48 5. Limit to: peer reviewed journals, English language, 2013-2016= 7 Care leaver search: 1. Keywords: foster care or child protection 2. Keywords: program or intervention 3. Keywords: employment or housing 4. Keywords: transition 5. Combine searches 1-4 =22 results
MEDLINE	1. Keywords: (child neglect) OR (child abuse) OR (child maltreatment) OR (child protection) =28879 2. Keywords: (program) OR (intervention) = 743796 3. Combine Search 1 and 2 = 2931 4. Limit year to 2013-2016= 516 5. Keywords: (review) = 2541095 6. Combine searches 4 and 5= 85 7. Limit to peer-reviewed journal articles and English language = 76 8. After discarding duplicates with PsycInfo results, = 43 Screening of titles and abstracts identified 6 potentially relevant papers

Titles and abstracts were screened with the following exclusion criteria applied to narrow results:

- Book reviews and Editorial overviews of journal special issues
- Case-studies
- Reviews focusing on risk factors/screening or impact of child maltreatment rather than on programs or strategies for prevention and treatment
- Reviews specific to low and middle income countries
- Reviews relating to specific groups (e.g. military families) or specific forms of maltreatment (e.g. fabricated or induced illness) or perpetrators of child abuse not identified within a family context (e.g. juvenile perpetrators of child sexual abuse)
- Literature published before 2013
- Papers not published in the English language
- Papers not published in peer-reviewed journals

Research institutes' websites

Research Institute	Web address
C4EO: Centre for Excellence and Outcomes in Children and Young People's Services	www.c4eo.org.uk
NICE: National Institute for Health and Care Excellence	www.nice.org.uk
The Social Research Unit at Dartington	http://dartington.org.uk/
Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI) at the UCL Institute of Education	www.eppi.ioe.ac.uk/cms
Australian Research Alliance for Children and Youth (ARACY)	www.aracy.org.au http://whatworksforkids.org.au/programs
Australian Institute of Family Studies: Child Family Community Australia / Closing the Gap Clearinghouse	www.aifs.org.au
Telethon Kids Institute	www.telethonkids.org.au
Parenting Research Centre	www.parentingrc.org.au
Centre for Community Child Health (CCCH)	www.rch.org.au/ccch
Australian Institute for Health and Welfare (AIHW)	www.aihw.gov.au
Social Policy Research Centre, University of New South Wales	www.sprc.unsw.edu.au
Centre of Excellence for Early Child Development	http://www.excellence-earlychildhood.ca
UNICEF Innocenti Research Centre	http://www.unicef-icdc.org/

APPENDIX D. Review methodology

A rapid evidence assessment (REA) methodology was used to identify relevant programs. This type of assessment uses similar methods and principles to a systematic review, but does not involve an exhaustive search of the literature. As such, the rapid review approach to evidence assessments may result in missing some relevant information (Ganann, Ciliska, & Thomas, 2010). Nevertheless, the approach is appropriate when a targeted search is required to identify relevant literature within a short timeframe.

The programs included in this menu of evidence were identified following a systematic search of:

- Peer reviewed journal articles in academic databases (e.g., PsycInfo, MEDLINE)
- Systematic reviews in the Cochrane and Campbell Collaboration databases
- Grey literature available on the websites of reputable and relevant organisations, research institutes, and national and international evidence databases
- Previous reports published by CCCH
- Internal CCCH bibliographic databases
- Evidence databases (e.g. Blueprints for Healthy Youth Development; California Evidence Based ClearingHouse for Child Welfare; Promising Practices Network on Children, Families and Community; and What Works for Kids)

Appendix B provides details of: the search strategies employed in academic databases, websites consulted, and reports identified in internal bibliographic databases. Following examination of almost 50 key papers, a 'long list' of more than 190 potentially relevant programs was constructed. This list of programs was then narrowed to those evaluated with at least one Randomised Controlled Trial (RCT) demonstrating a positive impact on:

- child maltreatment variables (e.g., abuse, neglect, CPS reports),
- placement and family reunification outcomes,
- child social or emotional wellbeing (e.g. internalizing and externalising problems, trauma symptoms), and health outcomes (e.g. substance misuse, risky sexual behaviour) among those who have been abused or neglected or are living in out of home care settings, and
- successful transitions to independent living.

Programs with a focus on child protection issues and developed specifically for culturally and linguistically diverse groups within Australia were also retained in the short list for further consideration, even if they did not have RCT-level evidence.
One program that did not specifically have a child protection focus, but has demonstrated very high recruitment rates with RCT level evidence of effectiveness on parenting outcomes, and demonstrated application within the Australian context was also considered for inclusion.
Programs broadly targeting child maltreatment risk factors (e.g. parent substance abuse, parent mental health, family functioning, and child behaviour problems) were not included in the short list unless there was direct evidence of an impact on one of the above criteria. Owing to time and resource constraints, school-based programs for the prevention of sexual abuse were also excluded.

Programs meeting the above criteria were investigated further and those with the strongest research evidence were considered 'best-practice' and selected for inclusion in the menu. Several 'promising' programs were also considered for inclusion, with special consideration given to those implemented and evaluated in Australia.

Criteria for best practice programs

1. The program must have been evaluated with effectiveness on relevant outcomes demonstrated in at least two randomised controlled trials (i.e. strong design and replication);
2. The program must have had at least two positive impacts on desired outcomes (must be statistically significant or change of at least 20%) and the program designers / authors should not report any negative or harmful effects.
3. There should be clear statements in the available information about what the program involves, whom it is for and why it is important (i.e. specificity).

Criteria for promising programs

1. The program has evidence to support its effectiveness but does not meet the standards required for best practice programs; and
2. The program is innovative in terms of content or delivery and/or is based on a strong research-based program logic.

Decisions about which programs could be considered promising were made by the researchers undertaking the project (from the Centre for Community Child Health). These decisions were based upon current knowledge regarding what works, as well as the combined knowledge and experience of the researchers involved. The Department of Health and Human Services was also invited to recommend the inclusion of promising programs not identified in initial searches conducted for the rapid review. Where there were a lot of programs in contention as promising, selection was made on the basis of which were supported by the strongest evidence and/or were the most innovative.

Using the menu

This menu showcases a selection of programs identified as best-practice or promising for the purposes of improving child and family outcomes within a child protection context. It is not intended as an exhaustive list of programs that may benefit children and families considered at risk of or facing child maltreatment problems. It should also be noted that not every effective and relevant program could be identified. This is for several reasons. First, many programs currently being implemented may be effective, but they may not yet have been evaluated. Second, the initial searches were contained to recent literature reviews in a limited number of databases and key websites. Third, time constraints meant program selection was limited to those with the strongest research evidence in the outcome areas listed above. Not all interventions can be tested using the strongest designs (for pragmatic and ethical reasons, for example). Nevertheless, such interventions may be effective. Finally, it should be noted that programs targeting broader risk factors (e.g., housing and employment stress, parent mental health, substance abuse, domestic

violence) and systemic changes are likely to be necessary to address child maltreatment and its associated problems. Consideration of such programs was beyond the scope of this project, but should be taken into account in policy and planning activities.

Although all programs included in the menu may be considered best practice or promising, those planning and delivering services should carefully consider the applicability and appropriateness of programs before selecting and implementing them in different communities. In many cases, it was not possible to determine the extent to which programs were successful in recruiting the target population. This is partly because recruitment of participants stops when a desired sample size is achieved, and the number of eligible participants is not always reported. As evaluations tend to focus on effectiveness, it was not possible to compare all programs in terms of how engaging they are. It is imperative that local contextual factors are taken into account if programs are to be engaging, sustainable and effective. If they are not, programs that have demonstrated effectiveness elsewhere may prove ineffective or even cause harm.

This menu of evidence should not be considered a static document. Developments in program design, implementation, and evaluation will continue and, as such, new programs that are equally or more effective and efficient may emerge. Similarly, it is possible that programs currently recognised as best practice or promising may not be so in the future. Evidence of ineffectiveness or damaging effects may also emerge and checks for such developments should be conducted before programs are implemented.

Selected programs are organised according to the four main outcome areas listed above, followed by those designed for Australian CALD and Indigenous populations, and approximately ordered within each category according to the strength of supporting evidence.

Programs preventing child maltreatment outcomes:

Best-practice:

- Triple P (Positive Parenting Program)
- Nurse Family Partnership (NFP)
- Parent Child Interaction Therapy (PCIT)
- Parents Under Pressure (PUP)
- Healthy Families New York (HFNY)

Promising:

- Attachment & Bio-behavioural Catch-up (ABC)
- Family Thriving Program (FTP)
- Early Start
- Safe Environment for Every Kid (SEEK)
- SafeCare
- Child Parent Psychotherapy (CPP; see programs to improve social and emotional welleing)
- Project Support
- Child and Family Interagency, Resource, Support and Training (ChildFIRST)

Programs impacting placement and family reunification outcomes:

Best-practice:

- Triple P (see entry under child maltreatment outcomes)

- Treatment Foster Care Oregon for Pre-schoolers (TFCO-P; formerly Early Intervention Foster Care; EIFC)
- Keep Safe

Promising:

- Fostering Healthy Futures
- Homebuilders
- Keeping Foster Parents Trained and Supported (KEEP)
- Fostering Individualised Assistance Program (FIAP)
- Treatment Foster Care – Oregon-Adolescents (see programs for social and emotional wellbeing)
- Multi-systemic Therapy for Child Abuse and Neglect (MST-CAN- see programs impacting child social-emotional wellbeing and health outcomes)

Programs improving social or emotional wellbeing and/or health outcomes (among abused or neglected children, but without evidence of reducing maltreatment).

Note: many of the programs impacting maltreatment or maltreatment potential also demonstrate evidence of improving social and emotional health (e.g. Triple P, NFP, and PCIT, ABC, SafeCare, ChildFIRST, PUP, Early Start, and Project Support; For brevity they are not duplicated below, but are presented in Table 1):

Best-practice:

- The Incredible Years
- Tuning into Kids
- Treatment Foster Care – Oregon-Adolescents (formerly Multidimensional Treatment Foster Care-Adolescent, detailed under placement and re-unification section)
- Keep Safe (formerly Middle School Success, detailed under placement and re-unification section)
- Kids in Transition to School

Promising:

- Child Parent Psychotherapy (CPP)
- Fostering Healthy Futures (see programs impacting placement/reunification)
- Multi-systemic Therapy for Child Abuse and Neglect (MST-CAN)
- Cognitive Behavioral Therapy for Sexually Abused Preschoolers (CBT-SAP)
- Big Brothers, Big Sisters
- Together Facing the Challenge
- Fostering Individualised Assistance Program (see programs impacting placement and reunification)
- Life Story Intervention
- Empowering Parents, Empowering Communities (EPEC)

Programs for successful transitions to independent living:

Promising:

- Take Charge

- Massachusetts Adolescent Outreach Program for Youths in Intensive Foster Care (MA Outreach)

Programs designed for culturally and linguistically diverse Australian populations:

Promising:

- Bending like a river
- Take Two (including Yarning up on Trauma)

Overview of programs

A total of 33 programs are included in this menu. The majority of these focus on families who are either at serious risk of child maltreatment, are receiving statutory child protection services, or have children in out of home care. This reflects a general focus on treatment rather than prevention or very early intervention. Similarly, only a few programs were identified at the other end of the spectrum, demonstrating effective interventions for the transition to independent living.
The majority of programs demonstrating some evidence of a reduction in child maltreatment (or its potential) utilised a home visiting approach. Of these, the programs supported by the strongest evidence were the Nurse Family Partnership, Parents Under Pressure, and Healthy Families New York. Programs utilising other approaches, such as parenting groups, individual family therapy, and referral to support services, included Triple P, PCIT, and SEEK, respectively.
Many of the programs demonstrating an effect on child maltreatment variables also demonstrated an impact on family functioning (e.g. parenting) and/or child social and emotional wellbeing (e.g. behaviour problems, internalising difficulties). Of those that appeared to include direct measures of maltreatment (rather than maltreatment potential), Triple P, the Nurse Family Partnership, and PCIT demonstrated impacts on both family functioning and child mental health. Of those demonstrating effects on child abuse potential, PUP, Early Start and ABC also impacted both family functioning and child social and emotional health variables.

Programs demonstrating a positive impact on permanency of placements or reunification with the birth family presented a mix of home-visiting and group-based interventions. Of these, only Treatment Foster Care-Oregon for Preschoolers (for children up to 6 years) also demonstrated a positive impact on both family functioning and child social and emotional health. For pre-adolescent children, Fostering Healthy Futures demonstrated positive effects on child mental health, as well as placement stability. Keep Safe and Treatment Foster Care Oregon-Adolescents demonstrated positive impacts on adolescent social and emotional wellbeing. The Fostering Individual Assistance Program also demonstrated an impact on both reunification and child social and emotional wellbeing, and serves children from 5-17 years. The programs that demonstrate effects on both placement permanency as well as social and emotional wellbeing tend to be resource intensive and involve substantial support to both foster parents and the children in their care. The least intensive of the programs demonstrating an impact on permanency and reunification were Triple P and KEEP, both of which involve weekly group sessions.

A variety of programs positively impacting social and/or emotional wellbeing and health behaviours were identified. These include a range of home visiting, group education, mentoring, and family therapy approaches. The most strongly supported of these programs included the NFP, Triple P, and PCIT, all of which have been evaluated in multiple RCTs and demonstrate effects on child maltreatment variables and family functioning as well. Other programs designed to improve child social and emotional wellbeing or health and supported by at least two RCTs include The Incredible Years, Tuning into Kids, Kids In Transition to School, Keep Safe, and Treatment Foster Care Oregon-Adolescents. The Incredible years is the most-studied of these programs and has

demonstrated effectiveness on child wellbeing as well as parenting practices. Similarly, Tuning Into Kids has been examined in multiple RCTs and demonstrated effectiveness for both child wellbeing and improved parenting.

In addition to replication of behaviour regulation effects, at least one RCT of Kids In Transition to School also demonstrated a positive impact on literacy, behaviour problems, and parenting practices. In addition to replication of effects on internalising and externalising symptoms demonstrated in two RCTs, Keep Safe appears to have a positive impact on substance misuse and permanency of placements (one RCT), and high-risk sexual behaviour, self-harm, offending and violent behaviour, and school activities (pre-post study). Similarly, Treatment Foster Care Oregon-Adolescents appears to have a positive impact on behavioural problems, but also criminal referrals and time spent in locked settings (as demonstrated in at least two RCTs). Promising programs with a focus on trauma recovery include Child Parent Psychotherapy (for children up to 5 years), CBT for Sexually Abused Preschoolers, and Fostering Healthy Futures (for pre-adolescent children).

One promising program not specifically designed for families at risk of child maltreatment or receiving statutory child protection services was also included in the social and emotional wellbeing section of the menu. This program, EPEC, is included because it utilises best-practice principles of engagement and has demonstrated high recruitment and retention rates with traditionally hard-to-reach or vulnerable families both internationally and within Australia. It has RCT-level evidence of effectiveness for child behaviour problems and parenting competence, with some effects as large as those observed for trials of programs with professional therapists. For these reasons, this program is also listed as promising.

There appear to be a variety of programs currently implemented to assist children currently in out of home care with their transition to independent living. Unfortunately, very few have been evaluated in RCTs. Shlonsky et al (2013) identified a systematic review of 18 independent living programs but reported that none had been evaluated in randomised controlled trials nor utilised a quasi-experimental methodology. Of the four independent living programs Shlonsky et al. identified as evaluated in a randomised controlled trial, three offered services (class-room based life skills, home tutoring, and engagement in employment related skills) already offered more generally in the community and were not considered effective as delivered in the programs. Thus, only one program appeared worthy of note (MA Outreach). Similarly, the result from this rapid review was that only two of the 17 identified programs met our inclusion criteria (Take Charge and MA Outreach). Take Charge involves weekly coaching sessions delivered within a school setting over a period of 12 months. Increased independent living activities and use of transition services have been demonstrated for this program, along with improved education planning and psychosocial functioning. MA Outreach has also demonstrated some positive transition effects. This program similarly involves weekly coaching, but is delivered over a more extended and flexible period of time (on average taking 16-18 months with an additional 6 months tracking). Outcomes include higher rates of participants: obtaining important documents such as birth certificates and driver licences, enrolling in post-secondary education, and staying in foster care past 18 years of age.

Only two programs specifically tailored to Australian Culturally and Linguistically Diverse groups met inclusion criteria. Neither has demonstrated effectiveness with an RCT evaluation. However, Take Two appears to show some promise with respect to child trauma and social and emotional wellbeing, while Bending Like a River demonstrates some promise with respect to improved parenting and understanding of child safety laws.

APPENDIX E. Key papers consulted

Key papers identified from internal CCCH database

Families who have some difficulties

Axford, N. and Barlow, J. (2013). What Works: An Overview of the Best Available Evidence on Giving Children a Better Start, Version 1.0. Totnes, Devon, UK: Social Research Unit at Dartington. https://dartington.org.uk/inc/uploads/What%20works%20%20Overview.pdf

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Moore, T.G., McDonald, M. and Sanjeevan, S. (2013). Evidence-based service modules for a sustained home visiting program: A literature review. *Prepared for the Australian Research Alliance for Children and Youth.* Parkville, Victoria: The Centre for Community Child Health at Murdoch Childrens Research Institute and The Royal Children's Hospital. DOI: 10.4225/50/5578D05386218

Wade, C., Macvean, M., Falkiner, J., Devine, B. and Mildon, R. (2012). Evidence review: An analysis of the evidence for parenting interventions in Australia. Melbourne, Victoria: Parenting Research Centre.
http://www.parentingrc.org.au/images/Resources/Evidence-review-Analysis-of-evidence-parenting-interventions/EvidenceReviewParentingInterventions.pdf
http://www.parentingrc.org.au/images/stories/evidence_review_parenting_interventions/main_report_evidencereviewparentinginterventions.pdf

Families at risk of child maltreatment

Fauth, R., Jelicic, H., Hart, D., Burton, S. & Shemmings, D. (2010). Effective Practice to Protect Children Living in 'Highly Resistant' Families. London, UK: C4EO (Centre for Excellence and Outcomes in Children and Young People's Services).
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Families receiving statutory child protection services

Australian Centre for Posttraumatic Mental Health and Parenting Research Centre (2013). Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect – Evidence, practice and implications. Report prepared for the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs. Carlton and East Melbourne, Victoria: Australian Centre for Posttraumatic Mental Health and Parenting Research Centre.
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Care leavers

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